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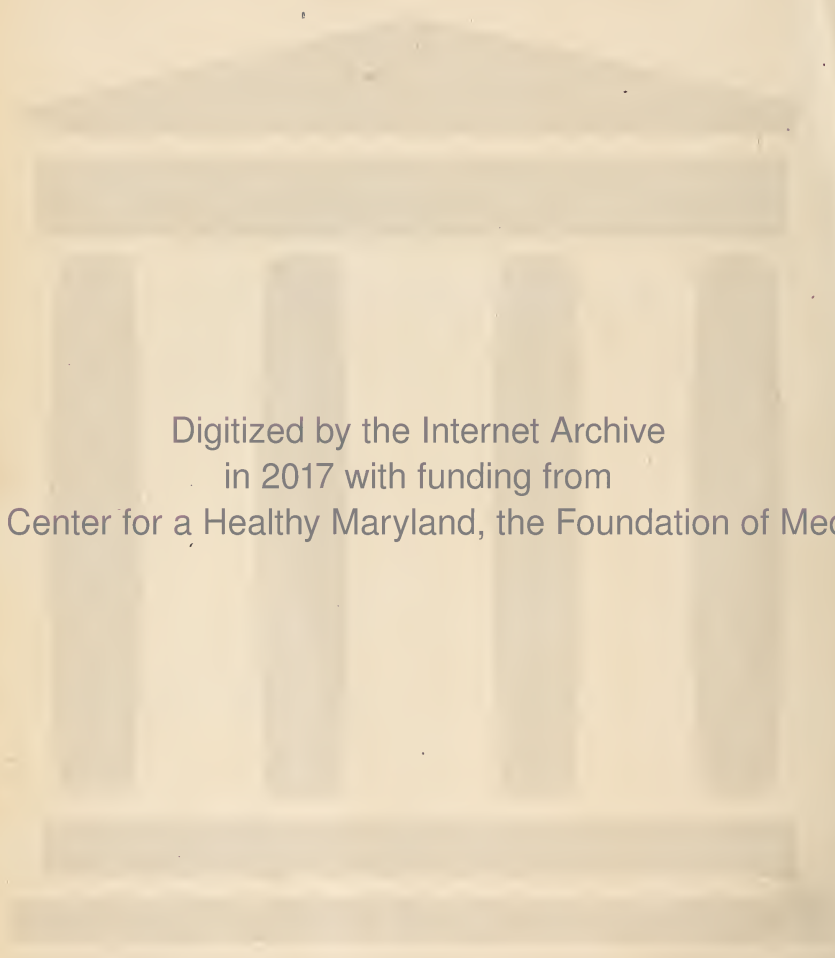
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## Original Articles.

### THE TREATMENT OF POSTERIOR DISPLACEMENT OF THE UTERUS.\*

BY J. WHITRIDGE WILLIAMS, M. D.,

Assistant in Gynæcology, Johns Hopkins Hospital;  
Pathologist to the Hospital for the Women of  
Maryland; Fellow of the American Gynæ-  
cological Society; Etc.

Our only excuse for the consideration of so hackneyed a subject as the posterior displacements of the uterus is the fact that so many new operations for their relief have been proposed during the past few years and so much doubt has been thrown upon the usual methods of treatment, that those of us who are not especially interested in gynæcology are apt to be in more or less doubt as to the treatment to be pursued in any given

case. That the subject is one of practical interest cannot be denied; and every one of us, who may have occasion to examine women for any cause, is certain to meet with cases of this variety and to be obliged to consider what is best to do for his patient.

As we all know, retro-displacements of the uterus are often of very frequent occurrence; according to Sängér, they are met with in about 16 per cent. of all gynæcological cases, and occur either as retroversions or retroflexions.

We do not pretend to say that the mere displacement of the uterus per se constitutes a disease; for we know that in many cases it may exist without giving rise to any symptoms whatever. This is particularly the case in women after the menopause, in a large proportion of whom, if for any reason they happen to be exami-

\*Read before the Medical Journal Club of Baltimore, February 14th, 1893.

ined, the uterus will be found either retroflexed or retroverted. On the other hand, there is a considerable number of cases in which the uterine displacement can only be considered as a complication of more serious affections, as in many cases of tubal or ovarian disease. But, even after making the necessary number of exceptions, there can be no doubt that in a very considerable number of cases we meet with symptoms, which will only disappear after the displacement is corrected, and which force us to treat displacements of the uterus as if they constituted a disease with definite pathological lesions, which has not, and, as far as I can see, cannot be proved.

Retroflexion is the more important form of the retro-displacements of the uterus, and in general our remarks will apply particularly to it; it being understood that any mode of treatment which is applicable to a retroflexion is also applicable to the less important retroversion.

From the standpoint of treatment, it is necessary to distinguish between those forms of retroflexion in which the uterus is freely movable, and those in which it is bound down to some portion of the pelvic contents by more or less dense adhesions. In other words, to distinguish between movable and adherent forms of retroflexion.

In general terms, this sounds simple enough, but in many cases, uteri, which appear densely adherent and impossible to replace after an ordinary examination, are readily replaced when the patient has been thoroughly relaxed by the use of an anæsthetic.

We will accordingly consider, in the first place, the treatment of movable retroflexions and then the treatment of

adherent retroflexions by non-operative procedures, and having shown what may be accomplished in this direction, we will then consider the propriety of surgical interference, what may be accomplished by it, and what operations are indicated under given circumstances.

*Movable retroflexions.*—Having decided by a careful bimanual examination that there is no other disease of the pelvic organs than the retroflexion, and that the uterus is freely movable, the first question to consider is how to replace it, and, having replaced it, how to keep it in position? The first question is readily answered by stating that there is only one proper method of replacing a movable retroflexed uterus, and that is by careful bimanual manipulation alone, without the aid of any form of instrument. In general, the reposition of the uterus is most readily effected with the woman in the dorsal position. Then, with one or two fingers of the left hand in the vagina and the right hand upon the abdomen, there should be no difficulty, provided the abdominal walls are fairly well relaxed, in taking the freely movable retroflexed uterus between the fingers of the two hands and restoring it to its original position. We are indebted to B. S. Schultze, of Jena, for demonstrating that this is the only proper procedure in these cases, and that the use of the sounds, elevators and the like is totally unnecessary. In some cases, the replacement may be facilitated by placing the patient in the knee-chest or semi-prone position. If there be any further difficulty in replacing the uterus, great assistance is frequently obtained by seizing the posterior lip of the cervix with a pair of bullet forceps or a corrugated tenaculum and drawing



down the entire uterus in the axis of the vagina, as recommended by Küstner in 1882; by which the fingers in the vagina or rectum are more readily able to control a greater portion of the posterior surface of the uterus than under the usual conditions.

By these means, we should always be able to replace a freely movable retroflexed uterus, and there is absolutely no necessity for the employment of the uterine sound, repositor or elevator, even though years ago their employment may have been advocated by the most eminent gynaecologists. At the present day, their employment indicates either a mournful lack of skill in bimanual manipulation, or shows that one prefers the methods of one's fore-fathers to those of more modern times.

In this connection, we would say that the use of the uterine sound should be restricted as much as possible, and in view of the number of pathogenic germs, which abound in abnormal vaginal secretions (and the secretions are always abnormal in cases requiring treatment), we do not consider that it should be employed except under antiseptic precautions. We regret to see that Pozzi, in the last edition of his excellent *Traité de Gynécologie* (1892) states that this is the most generally employed method for replacing movable retroflexions.

Having thus replaced the uterus in its normal position, we have to consider how it may best be held in place, and this will be taken up later on.

Adherent retroflexions. Were the reposition of adherent retroflexions as readily accomplished as in the cases just under consideration, the question of the

treatment of retroflexion of the uterus would be greatly simplified; but unfortunately such is not the case.

In cases of *adherent retroflexion*, it is particularly necessary that the condition of the pelvic organs be accurately ascertained; and if an accurate vaginal examination can not readily be made, we should not hesitate to make a careful examination under anaesthesia.

Having satisfied ourselves that there is no active disease of the tubes and ovaries and that the retroflexion is not a complication of some more serious trouble, we should attempt to make out the nature and location of the adhesions, which hold the uterus in its abnormal position, and having satisfied ourselves of the exact nature of the adhesions with which we have to deal, we are in a position to know with more or less certainty what will be the best course to pursue in attempting to do away with them.

Any inflammatory processes should be done away with before the active treatment of the retroflexion is attempted.

In a considerable number of cases, we have obtained most excellent results by a combination of massage and tamponade of the vagina. In these cases, with the patient on her back, we make a most careful bimanual examination, and at each examination attempt gradually to stretch the adhesions, which hold the uterus in its abnormal position; we make repeated attempts to replace the uterus by bimanual examination, never employing any great amount of force, and allowing the uterus to fall back as soon as any great resistance is encountered. After this has been persisted in for a few minutes, a bivalve speculum is

introduced and two absorbent cotton tampons, soaked with equal parts of boro-glyceride and glycerine, are introduced and packed up into the posterior fornix with considerable force, then a wool tampon is introduced, and the speculum removed, care being taken in so doing. After two days, the tampons are removed and the same process repeated. By this method we are able to subject the posterior surface of the uterus to constant pressure from below, and at the same time whatever may have been gained by the massage is not lost between the various sittings. Of course when the uterus is very adherent, such a mode of treatment is quite prolonged, but in a large proportion of cases we are at last able to free the uterus from its adhesions and to bring it into a condition suitable for its reposition.

In speaking of massage, we do not care to be understood as recommending the typical Thure Brandt method, which does not appear well suited for use among the better class of women in this country.

If by these means we are unable to attain our end, we should resort to the method of Schultze for the separation of the adhesions. The woman should be anæsthetized and placed in the dorsal position, two fingers of the left hand should be introduced high up into the rectum above the ampulla, when they readily control the entire posterior portion of the pelvis; at the same time the right hand is used from the abdomen, thus giving an opportunity for the most careful bimanual examination. After the individual adhesions have been accurately mapped out, the attempt is made to sep-

arate them from the uterus by a careful scraping motion of the fingers, the object being to loosen the adhesion at its uterine attachment rather than at its other point of attachment.

This method requires the most refined power of palpation, and is without doubt associated with a considerable element of danger. However, the danger in this case is far less than that which accompanies an attempt to replace an adherent uterus by means of the uterine sound or repositor; for in one instance we have at least some control of our force, while in the other it is exerted blindly.

By these means in the great majority of cases, we are able to free the uterus from its adhesions, when it is in a condition to be replaced; but in a certain number of cases it is impossible to free the uterus from its adhesions, and it is in these cases, if they give rise to symptoms of a sufficiently grave character, that cœliotomy may be indicated.

Having once freed the uterus from its adhesions, it is then replaced bimanually as before mentioned, when it becomes necessary in most instances to provide some means for its support. In a few cases, after the uterus has been freed from its adhesions and placed in the proper position, it will retain it without the use of any kind of support, but in the vast majority of cases some kind of support is necessary. The only support which is at all satisfactory is that afforded by some form of pessary; those which are most worthy of mention in this connection being the Smith, Hodge, Thomas or Schultze's figure of eight pessary; in some instances a soft ring pessary is very useful.

It is unnecessary to lay stress upon the

fact that the size and form of the pessary should conform to the requirements of the individual case, and should not be chosen at random. It is only when an accurate study of the conditions in each case is made that one can expect anything like good results from the use of these very useful instruments.

We can not agree at all with those who unreservedly condemn the use of pessaries, and we consider that their condemnation is only evidence of their total ignorance of the principles upon which the employment of pessaries is based.

But, however useful pessaries may be, we do not claim that they will absolutely cure the trouble in all cases, even when we are able to replace the uterus. Indeed, the contrary must be confessed, if by cure we mean that the pessary will enable the uterus and its supporting structures to reassume their normal tone, and at last remain in place without its assistance. Such a result may be designated as an absolute cure, and only occurs in about twenty-five per cent. of the cases treated. On the other hand, in a much larger proportion of cases, the uterus remains in place and all the symptoms are removed as long as the pessary is employed, but recur as soon as it is removed. These we may designate as relative cures, and they occur in from forty per cent. (Sänger) to sixty per cent. (Klotz) of all cases conscientiously treated.

Thus it is seen that a considerable number of cases remain in which the treatment by pessary is of no avail, or in which it is impossible to free the uterus from its adhesions. It is only in these cases that there should be any thought of operative treatment, and then only when the displacement gives rise to symptoms of considerable gravity.

We will now review briefly the principal operative measures which have been proposed for the relief of this affection, and then consider which of them are of value and in what cases the different operations may be indicated.

It is apparent that any laceration or relaxation of the pelvic outlet should be repaired, especially if we believe that the relaxed vaginal walls are unable to afford the requisite support for a suitable pessary. In these cases, Emmet's perineal operation usually gives the greatest satisfaction. The repair of a relaxed vaginal outlet can only be of service in cases in which the uterus is movable; for it is evident that the use of a pessary is not indicated when the uterus is adherent. In some cases, however, curettement and a subsequent perineal operation will lead to the total disappearance of the symptoms, without any attempt being made to restore the misplaced uterus to its proper position.

The past ten or twelve years have witnessed the greatest possible activity in devising new operations for the cure of retroflexions of the uterus, and at present they have become so numerous as to be most confusing to those who are not especially interested in the surgical side of gynecology.

The first operation for retroflexions of the uterus which enjoyed any extensive popularity was the Alquié-Alexander operation. This operation was proposed some fifty years ago by Alquié and carried into execution by Alexander, of Liverpool, in 1881. In performing it, an incision is made over the external inguinal ring; the round ligament is isolated and drawn out as far as is necessary to hold the uterus in a somewhat normal



position, it is then sutured and the wound closed.

The operation soon became popular and was performed on a large number of cases, but of late it has fallen somewhat into disrepute, the general opinion being that it fails to fulfill its object in most cases. It is obviously only applicable to cases in which the uterus is freely movable; for the round ligaments are not sufficiently strong to permit of dragging the adherent uterus forward.

One of the objections urged against the operation is that the round ligaments are often so thin at their peripheral extremities that it is impossible to find them at the operation. To obviate this difficulty Edebohls (1891) advises opening up the entire inguinal canal and isolating the round ligament at the internal ring, where it is much larger, and then stitching it to the side of the canal. This method, he states, does away with all the objections which have been urged against the original operation.

Operations, which also depend upon shortening the round ligaments, have been devised by Bode, E. P. Dudley and Wylie. In them, coeliotomy is first performed and then the round ligaments are shortened by folding them upon each other in various ways and then stitching them in the required position.

The operation of which the most has been written is that of ventral fixation of the uterus or hysterorrhaphy, or the suturing the retroflexed uterus to the anterior abdominal wall after laparotomy. The term hysterorrhaphy was proposed by Kelly, but has not been employed to any great extent; and we consider the term ventral fixation of the uterus preferable to it, for hysterorrhaphy signi-

fies only stitching the uterus without indicating where or to what it is to be stitched. Of course, in the early days of ovariectomy, when the pedicles were secured by means of a clamp without the abdominal walls, this frequently happened; but then it was merely the result of chance and not of design.

The first operation which was really undertaken with the primary object of fastening the retroflexed uterus to the anterior abdominal wall was performed by Koeberle in 1878, in a severe case of retroflexion occurring in a Polish countess. After removing both tubes and ovaries, he stitched the pedicles into the abdominal wound and then closed it. The operation was successful, but apparently was not repeated, and was in a fair way of being lost sight of, when, in 1886, Olshausen reported two cases in which he had stitched the uterus to the anterior abdominal walls by passing sutures through the cornua, just at the point from which the round ligaments come off. Olshausen expressed himself very guardedly concerning the operation and stated at the time that it was quite possible that fastening the uterus to the abdominal wall might lead to abortion, in consequence of the tension exerted upon the enlarging uterus by the adhesions, and he advised that the operation be employed only in women who were not likely to become pregnant. He also stated that the operation could be justified only in a very few otherwise hopeless cases of adherent retroflexion or prolapsus.

Olshausen's paper was quickly followed by a number of others, particularly those of Sanger, Leopold, Klotz and Kelly, and the indications for the operation

were rapidly expanded so as to include not only the hopeless adherent cases, but also those in which the uterus was freely movable. By these and other operators cœliotomy was done and the uterus, if adherent, freed from its adhesions and stitched to the anterior abdominal wall by various methods; Olshausen and Säger passed the sutures through the cornua of the uterus; Leopold, Czerny and Tait stitched the fundus directly to the abdominal wall, after denuding a portion of the anterior surface of the fundus of its peritoneal covering, and Kelly made use of the ovarian ligaments as a means of attachment. Indeed, every possible means of attachment is employed, and all of them yield moderately good results, as far as keeping the uterus in place is concerned.

The operation was not taken up generally without a struggle and many objections were urged against it, the principal one being its probable effect upon pregnancy after the uterus had become adherent to the abdominal wall, when it was feared that the tension exerted upon the enlarging uterus by the adhesions might lead to abortion.

The results of the operation, however, soon proved that the danger did not exist, and in 1891, Säger published an article upon the relation of the operation to pregnancy, in which he stated that thirteen full term labors had occurred in one hundred women in whom the operation had been performed. When it is remembered that the first ventral fixation was done in 1886, and that it was not employed to any extent until several years later, and also that unmarried women and those past the menopause are included in the one hundred cases, it

can not be said that the operation exerts a very deleterious effect upon pregnancy.

It was also feared on account of the possibility of portions of the intestines becoming strangulated by the adhesions between the uterus and the anterior abdominal wall. The validity of this objection was illustrated in several cases of E. P. Dudley, which he had operated upon after Kelly's method, and in which an unsatisfactory result led to a second cœliotomy. In two cases, on opening the abdomen a second time, he found the uterus separated about two inches from the anterior abdominal wall, and the intervening space filled with a mass of adherent intestines. Fortunately this did not lead to strangulation, but it proved that the objection was valid, and not merely theoretical.

Freund objects that the operation makes an abdominal organ out of one which is naturally intended to remain within the pelvis. This is a more theoretical objection; and as long as the results justify the operation, it would appear to be a matter of very little importance whether a portion of the uterus were within the abdomen or not.

A much more rational objection is that of Küstner, who states that the operation merely substitutes adhesions in another place for those which formerly held the uterus in its abnormal position, and that he can not see the advantage of performing a more or less dangerous operation simply for the sake of substituting one form of pathological adhesions for another. To obviate this objection, he performed cœliotomy, loosened the uterus from the adhesions which bound it down and placed it in its normal position; then, instead of

stitching it to the abdominal wall, held it in position by a pessary, which was introduced by an assistant into the vagina, while the abdomen was still open. He did this in a number of cases and stated that the results were perfectly satisfactory.

Frommel, of Erlangen, does not approve of ventral fixation for the reason that it does not attempt to deal with the primary cause of the retroflexion, namely, the relaxation of the utero-sacral ligaments; and he proposed the more rational but also more dangerous operation of shortening the utero-sacral ligaments after cœliotomy. For this purpose, he places the patient in Trendelenburg's position, frees the uterus from adhesions and then takes up the utero-sacral ligaments and stitches them to the lateral walls of the pelvis; the effect of which is to shorten them and at the same time to change their direction. This throws the uterus forward, and in the one case in which Frommel performed the operation, was perfectly successful. This operation has been admitted on all sides to be more rational than that of ventral fixation, but at the same time it can not be denied that it is considerably more dangerous, and it is on that account that it has not been taken up by other operators.

Indeed, after considering all the objections urged against ventral fixation of the uterus, one is almost forced to the conclusion that most of them are not of great importance and that the great obstacle to the widespread adoption of the operation is the fact that it necessitates the performance of cœliotomy, which, even in the hands of the most skillful operators, can not as yet be considered as a slight operation. In other words, it is

the thought of subjecting a woman to an operation, whose primary mortality can not be said to be much less than five per cent., even by the most sanguine laparotomists, for the questionable cure of an operation affection, which, even in its most aggravated form, does not of itself lead to death. It is the recognition of the inequality which exists between the results of operation and its dangers, which causes the general practitioner to hesitate before submitting his patients to the operation, and which also causes conscientious gynæcologists to perform it only when most urgently indicated, and in the mean time to attempt to discover some less dangerous and more ideal method of treatment for the cases of retrodisplacement of the uterus, which are not amenable to non-operative methods of treatment.

Possibly it was this consideration which led Kelly to attempt to suture the movable retroflexed uterus to the abdominal wall without opening the abdomen, by merely passing a large curved needle through the abdominal walls and the fundus of the uterus, which was held firmly against the anterior abdominal wall after which a silk-worm-gut suture was drawn through and fastened and allowed to remain for a period of several weeks. The operation, however, proved a failure, as we showed in an article written several years ago.

A somewhat similar operation was proposed by Cavena, in which a small incision was made down to, but not through the peritoneum, when the uterus could readily be seen beneath it; the uterus was then stitched to the abdominal wall without entering the peritoneal cavity. This, likewise, was not a glittering success, but it was certainly



less dangerous than Kelly's method, in that it permitted the operator to see to a certain extent what he was attempting to do.

In 1891, Krug, in an article entitled "Transperitoneal Hysterorrhaphy," described a somewhat similar operation, which, however, gave excellent results in six cases. He places the patient in Trendelenburg's position, so that all the intestines fall away from the pelvis and then an assistant presses the uterus forwards against the anterior abdominal wall. He then makes a small incision down to the peritoneum, but not through it, and with the sharp edge of a Hagedorn needle scrapes off the peritoneum from a small portion of the anterior surface of the uterus. He then passes his sutures through the abdominal walls and the fundus of the uterus, without having introduced his fingers in the peritoneal cavity. This class of operations are necessarily applicable only to movable retroflexions. In attempting to devise operative methods less dangerous than ventral fixation, another class of gynecologists turned their attention to operations within the vagina, and as a result a number of vaginal operations have likewise been suggested.

The earliest of these was that of Rabenau, who suggested the excision of a triangular bit of tissue from the anterior portion of the cervix. This, however, was not successful and now possesses only a historic interest. It was also attempted to reach the utero-sacral ligaments from the vagina and shorten them in various ways. Operations of this character having been performed by Herrick, Freund and Stratz with fairly good results, but the various operations do not appear to have spread to any

great extent beyond their originators.

In 1888, Schücking published a short account of an operation, which was certainly a step in the right direction, even while, surgically considered, it was open to the most severe criticism. In this operation, which is applicable only to movable retroflexions, he replaced the uterus and with a sound in the bladder as a guide, passed a curved needle, protected by a canula, through the anterior wall of the uterus and out again through the anterior fornix of the vagina; a silk-worm-gut ligature was then drawn through, when one end of it hung from the anterior fornix and the other from cervix. On drawing on the two ends, the uterus was readily anteflexed; he then tied the ligature, introduced a Smith-Hodge pessary, and, on removing the suture six weeks later, found the uterus permanently anteflexed.

The operation as originally proposed was certainly open to many objections, and it was no less than a miracle that the bladder and intestines were not frequently wounded; according to Zweifel, the bladder was wounded in about seventy per cent. of all cases operated upon. The ligature was also certain to cut through the cervix, and it was impossible to keep the uterus and its contents aseptic. In spite of all these objections, the operation was taken up by Zweifel and Klotz, and was soon modified by the former so as to become more of a surgical procedure. Zweifel's modification consists principally in separating the bladder from the anterior surface of the uterus, so that all possibility of injury to the bladder by the ligature is avoided; and also by fastening either end of the ligature with shot, so as to prevent it from cutting into the tissues.

The modified operation was accepted by Schücking and proved highly successful. It is most highly endorsed by Zweifel and Klotz, and it will be readily understood what Klotz's endorsement means when it is stated that he had performed sixty-two ventral fixations, and that he gave up that method of operating for Schücking's vaginal method, and up to 1891 had performed eighty-one vaginal fixations. Up to 1891, Schücking's operation had been performed 217 times and 27 of the women operated upon had since borne children.

At the meeting of the Berlin Gynaecological and Obstetrical Society, held July 8, 1892, Dührssen, Gusserow's assistant, described a method of operating, which certainly far surpasses any other vaginal operation yet suggested, both from a theoretical and surgical point of view. He makes a transverse incision two to three centimetres long in the anterior fornix of the vagina just anterior to the attachment of the vaginal portion of the cervix, and then separates the bladder from the anterior surface of the cervix and the body of the uterus as high up as possible without breaking through into the peritoneal cavity, just as one does in the first step of a total extirpation of the uterus by the vagina. A sound is then introduced into the bladder to act as a guide, and the uterus is thrown forward by a second sound, then a ligature is introduced into the anterior wall of the uterus as high up as possible, but is not tied and is to be used simply as a tractor. On making traction upon this, one is enabled to pass a second ligature above it, and so on until three or four tractors have been passed and we are enabled, by their aid, to draw

the fundus forwards and downwards and hold it in the desired position. Then three silk ligatures are passed through the anterior wall of the uterus, and above the highest tractor, and then through the vaginal wall just in front of the incision, and include its entire thickness except the mucosa. They are then tied, cut short and the incision in the anterior fornix closed; the vagina is packed with gauze and the woman put to bed and kept there for about two weeks.

Dührssen has performed this operation 140 times in all and none of the women have been seriously ill from it. 89.4 per cent. of the cases operated upon have been permanently cured. This is certainly a brilliant showing, and, as we said above, the operation appears to be the most rational of all the vaginal methods yet suggested.

An operation, more or less similar to the above, was described by Mackenrodt one month before Dührssen's paper was read, but he had not given his operation anything like the trial to which Dührssen had subjected his own operation.

There is another vaginal method of treating obstinate retroflexions, and that is the vaginal extirpation of the entire organ. The uterus has been removed for this indication by Richelot, Bouilly and Kelly, but it is not a method of treatment which should commend itself to conservative surgeons.

We have thus attempted to give an outline of the various modes of treatment for retroflexion of the uterus, and before closing, we desire to indicate our own ideas as to the proper course to be pursued in the treatment of these cases.

In all cases in which the uterus is

movable, it should be replaced by bimanual manipulation and a suitable pessary introduced.

In cases in which the uterus is adherent, we should attempt to free it from its adhesions by massage and the use of vaginal applications, and failing in them, we should resort to Schultze's method of loosening the adhesions under an anæsthetic.

If by these means we are able to free the uterus from its adhesions, it should be replaced and a suitable pessary introduced. If necessary, the vagina and perineum should be repaired by a plastic operation.

It is only in cases in which the pessary treatment is of no avail, or in cases in which the uterus cannot be freed from its adhesions, that there should be any thought of resorting to operative treatment, and then only when the retroflexion gives rise to symptoms of considerable gravity.

The practice of operating at once upon a case of retroflexion, without an attempt at more conservative treatment, cannot be reprehended too strongly.

The operative treatment of retroflexions uncomplicated by tubal or ovarian disease should differ as the uterus is movable or markedly adherent. If the uterus be movable we do not consider ventral fixation a justifiable operation, and would most emphatically recommend some form of vaginal fixation, preferably Dührssen's method. We have tried this method ourselves, and from our limited experience are inclined to believe that it will accomplish all that Dührssen claims for it.

If, on the other hand, we have not succeeded in freeing the uterus from its ad-

hesions, and the symptoms are sufficiently grave to justify a capital operation, there can be no doubt as to the propriety of performing cœliotomy and stitching the uterus to the abdominal walls by one or other of the methods mentioned above.

We do not wish to be understood as being opposed to ventral fixation, for we are not; but we are opposed to indiscriminate and reckless operating upon this class of cases.

The consideration of the treatment of retroflexions occurring as complications of serious tubal or ovarian disease resolves itself into the treatment of the primary affections, which does not come within the scope of this article.

1128 Cathedral Street.

It is one of the attributes of a good teacher that he knows how to say things in a way to make them remembered. During my second year at the Jefferson Medical College in Philadelphia, writes a physician in the *New York World*, I had a class-mate whom it would not be uncharitable to call a dullard. One of the professors was in the habit of taking the boys unawares and quizzing them. He said to this fellow one day: "How much is a dose of——?" giving the technical name of croton oil. "A teaspoonful," was the ready reply. The professor made no comment, and the fellow soon realized that he had made a mistake. After a quarter of an hour he said: "Professor, I want to change my answer to that question." "It's too late, Mr. —," responded the professor, looking at his watch. "Your patient's been dead fourteen minutes."—*Memphis Med. Monthly*.



## THE LANGDON RECTAL TUBE.\*

BY SAMUEL T. EARLE, M. D.,  
OF BALTIMORE.

I would like to call the attention of the Society to this very useful and superior appliance, because it has so many advantages over those heretofore in general use, and because the rectal tube is so necessary to the armamentarium of every general practitioner. It was first introduced by Dr. W. F. Langdon, Professor of Anatomy in Miami Medical College, Cincinnati, Ohio.† It is five feet long, one half inch in diameter, and has a canal running through it one-eighth of an inch in diameter, with the opening direct at the distal extremity instead of on the side as is usually the case. Its advantages are its length, thickness of its walls and direct opening. Until very recently it was thought to be either hazardous to introduce a tube into the rectum and large bowel farther than eighteen inches, or unnecessary; and it was left to gravitation, through position to fill the remainder of the large bowel with the fluid that was being injected. The results of several years use with this tube, in the hands of Dr. Langdon and others, has proven such a fear to be groundless on the one hand; while on the other, gravitation is insufficient to overcome certain obstacles to filling the whole of the large bowel with injections. In cases of fecal impaction, where it would be impossible to get the injection above the fecal mass by gravitation, or even by a safe degree of pressure, the tube is sufficiently stiff to be pushed around it, and the injection deposited behind it. The

thickness of its walls is sufficient to prevent that degree of bending upon itself that would enable it to take the reverse direction from that intended, while being introduced; or to obliterate its canal. The direct opening in the distal end has the advantage of being more easily kept open by the direct flow of the fluid passing through it, and also of distending the bowel in front of the tube more easily with the fluid as it escapes. In examinations for strictures high up in the bowel, above the reach of bougies, it can be used with safety and satisfaction. I had a case in point only a few weeks ago where a patient came to me supposing he had a stricture of the rectum; in fact had been treated for it some years ago. I introduced first a No. 5, then No. 9, Wales bougie, and not meeting with any obstruction, I introduced the Langdon tube its full length without the slightest difficulty, allowing some cottonseed oil to flow through it while being introduced.

I was thus enabled to satisfy myself that there could not be any serious stricture anywhere in the large bowel, and what was next in importance and unexpected to me, was, that such a demonstration at once allayed all fears of a stricture in the mind of my patient. But one of the most important uses of this tube to the general practitioner, as has been pointed out by Dr. Ricketts, is in rectal alimentation. Unquestionably the difficulty in the way of such treatment by the old method of merely injecting the nourishment into the rectum has been its natural intolerance to a sufficient quantity to sustain the patient and the increased sensitiveness such injections produce, when repeated often.

\*Read before the Clinical Society of Maryland at one of its Regular Meetings during January 1893.

†See paper read by Dr. Edwin Ricketts, of Cincinnati, before the Va. Med. Society, 1893.

It is the habit of the rectum, in a normal condition, to expel its contents, when they cause a certain degree of distention, nor is that degree nearly so great as is generally supposed, except when acquired by long disregard of nature's warnings. With this tube the whole of the large bowel can be utilized for this purpose, enabling us to use very much larger quantities, insuring us a very much larger and better surface for absorption, and saving the rectum almost entirely from undue distention. Still another very important use of this tube, and one which cannot well be secured by any other means of which I am aware, is in the treatment of Oxyuris Vermicularis, thread worm. Heller has shown\* that these worms live principally in the cæcum and lower part of the ileum, and that it is principally the females, when about to deposit their eggs, who descend into the rectum. It will readily be seen how useless it would be to try to relieve a patient of these troublesome parasites by medicated injections in the rectum; on the other hand, what better means could be devised to meet the needs of the case than the Langdon rectal tube, which enables us to inject the medicated solution directly to the normal habitat of these worms?

1431 Linden Avenue.

#### UTERINE HÆMATOCELE IN A GIRL AGED ELEVEN.

At the session of the London Clinical Society, Feb. 10th (*Lancet*). Mr. Barker described a case of Subserous Uterine Hæmatocele in a girl aged eleven, simulating Acute Appendicitis; laparotomy was

performed with success. Taking the view that the child was suffering from the latter disease in a most typical form, Mr. Barker opened the abdomen in the right linea semilunaris over the cæcum but found the latter and the vermiform appendix perfectly normal. Some turbid, brownish serum, without lymph, flowed from the direction of the pelvis, and feeling in this direction the right Fallopian tube and ovary were found to be swollen and twisted, and when brought into view were seen to be quite black from blood effused under their serous coats. Tracing this effusion inwards it was found to expand into a large subserous hæmatocele behind the uterus. This tumor nearly filled the pelvis and corresponded with the swelling felt per rectum before the operation. This brownish serum in the pelvis had probably transuded from it; it was quite smooth on the surface and was inflamed. The condition was now recognized, and it was felt that no attempt should be made to remove the blood tumor. The serum was therefore sponged out and the abdomen was closed in the usual manner. The child made an uninterrupted recovery. On leaving hospital on the thirty-first day after the commencement of the last attack the hæmatocele, as felt from the rectum and vagina, had diminished in size. The patient was watched for a month or two subsequently, but there was no return of the symptoms suggesting any attempt at very early menstruation. The case was recorded as possessing pathological, clinical and surgical interest, and as being probably a rarity; Mr. Barker was unable to find any account of a pelvic hæmatocele in a girl so young as the patient in question.

\*Ziemssen's Cyclopædia, Vol. VII, p. 756.



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BALTIMORE, APRIL 29, 1893.

### Editorial.

#### BALTIMORE AS A CENTRE OF MEDICAL EDUCATION.

The great number of graduates this spring from the medical schools of Baltimore has excited much comment on the part of that class of persons in the community which is to furnish them with their future means of support.

At first one might suppose that the size of the graduating class is due to some lowering of the standard of excellence; but this does not account for the phenomenon, since there is sure ground for the belief that the requirements are becoming more strict in all of our schools. Yet the number of graduates yearly increases.

There is, of course, an unusual haste to graduate begotten of the nearness of the time when the three-year course shall be obligatory. But it is easier to graduate in some other cities of the Union than here. In fact, the man

who presents himself for examination in our schools is really putting himself to unnecessary trouble; elsewhere he can get a diploma without any study, any knowledge, or any risk of being plucked.

The presence of the John Hopkins foundation has undoubtedly drawn the attention of all to the educational advantages of our city. As the requirements of its medical school under the Garrett stipulations will probably make it largely a training school for medical teachers, and a post-graduate school, the older medical colleges of the city are coming to look upon it as about the best advertisement that could possibly have been devised for their benefit. Accordingly, they are endeavoring in every way to fit themselves for the training of the ordinary practitioner. With great self-sacrifice they add year by year to their corps of well furnished lecturers: erect magnificent laboratories and call men trained in the Hopkins or other first-class schools to direct them and extend their hospital facilities to suit the demands of modern medical science.

It cannot be denied that in all of our schools many students graduate who ought to be rejected. But it is true that each class is better trained than that which preceded it. The student who desires to fit himself well for practice can find no better place than Baltimore. Our best graduates are undoubtedly the equals in all essential attainments of any graduates in the country.

With the admirable post-graduate course of the Johns Hopkins Hospital, established several years ago, in every special branch of medicine except obstetrics, which is well taught in our city Maternites, Baltimore has good reason to



claim a place among the great American centres of education.

For the future we may confidently expect a steady advance along every line of medical education.

With sincere pride in our city's attractions we invite young men who desire to prepare themselves for a medical career, to visit Baltimore and see for themselves the great educational institutions which have been founded in our midst.

### JOURNAL CHANGE.

In deference to the very positive preference expressed by our subscribers for pages cast in double column, the proprietors have decided to introduce the change with the first number of the new volume.

Every effort will be made to keep the JOURNAL up to the standard of excellence to which it has attained, and further improvements will be introduced as they are deemed feasible.

Hoping that our subscribers and contributors will continue their kindly interest in our JOURNAL, we would take this opportunity for expressing our thanks to them for their support in the past. We would assure them, also, that words from them either of criticism or of approval will always meet with grateful appreciation.

### Reviews, Books and Pamphlets.

*Hand-book of Massage*; by EMIL KLEEN, M. D., Ph. D., Practicing Physician in Carlsbad, Bohemia. Authorized translation from the Swedish, by Edward Massey Hartwell, M. D., Ph. D.,

Director of Physical Training in the Public Schools of Boston; late Associate in Johns Hopkins University. Philadelphia, 1892: P. Blackiston, Son & Co., 1012 Walnut Street. Cloth, octavo, 315 pages, price \$2.75.

Having had the honor of Dr. Hartwell's acquaintance during his residence in Baltimore, we take especial pleasure in the perusal of his excellent translation.

We feel indebted to him for placing within our reach and before the American profession a treatise on massage which can be relied upon as a fair and careful presentation of the uses and limitations of massage; a therapeutic agent, practically unknown to the American physician, which is possessed of great power for good if intelligently employed.

What we need is a hand-book of massage in English from a physician who is familiar with its virtues, yet who, while recognizing its simplicity, does not attempt to recommend it as a panacea for all human ailments, and does not hesitate to protest against the puerile, and even vicious, uses to which it has been put by enthusiasts. Such a treatise Dr. Hartwell has furnished to us.

After a highly laudatory introduction by Dr. S. Weir Mitchell, the volume proceeds to give the history of massage, its indications and contraindications, and then its application in surgical cases and in certain definite medical complaints of various organs.

We recommend the book to the attention of every reader; for every practitioner ought to possess a standard work on massage, such as that before us. Even the busy doctor, who is pressed for time and cannot get trained nurses, may glean from Dr. Hartwell's book an insight into

the principles of massage and many little points in its application which will be of great value to him in the handling of certain minor medical and surgical troubles.

*Manual of Chemistry. A guide to lectures and laboratory work for beginners in chemistry. A text-book specially adapted for students of Medicine and Pharmacy;* by W. SIMON, Ph.D., M.D., Prof. of Chemistry and Toxicology in the College of Physicians and Surgeons; Professor of chemistry and Analytical Chemistry in the Maryland College of Pharmacy, Baltimore, Md. Fourth edition, thoroughly revised, with forty-four illustrations; and seven colored plates, representing fifty-six chemical reactions. Philadelphia, 1893: Lea Brothers & Co. Octavo, cloth. Pages 493. Price \$3.25.

It is a pleasure to us to note the success of this work by a Baltimore teacher. That a new edition has been called for within twelve months after the issue of the last is sufficient proof that the writer has met the needs of the medical student and the physician.

Such changes and additions as the progress of science demands have been made to bring the work thoroughly up to date. Yet the author has maintained a judicious conservatism in the adoption of recent changes in nomenclature, etc.; not caring to be more progressive than the new edition of the United States Pharmacopœia, the standard in these matters. The color plates are very beautiful and constitute quite a feature of the book. We heartily recommend the work of Professor Simon to the attention of all students and practitioners.

*A System of Genito-Urinary Diseases,*

*Syphilology and Dermatology by various Authors.* Edited by PRINCE A. MORROW, A.M. M. D., Clinical Professor of Genito-Urinary Diseases, formerly Lecturer on Dermatology in the University of the City of New York, etc. Volume I, Genito-Urinary Diseases. New York, 1893: D. Appleton & Co. This first volume is a very handsome royal octavo of 1074 pages, beautifully illustrated and executed. Its themes have been distributed for discussion among thirty-two well-known specialists and teachers of New York, Philadelphia, Boston, Chicago, St. Louis, Brooklyn and Montreal.

If the two remaining volumes are the equals of that before us, as undoubtedly they will be, the cyclopedia will be a very popular one in America.

We can not now minutely review the contents or weigh the statements of the volume before us. It is chiefly valuable as giving the practical experience of expert American workers on themes assigned to them.

We cannot recommend as a thoroughly exhaustive treatise on genito-urinary diseases, a work in which the only sugar-tests mentioned are the Fehling and the Fermentation tests. This, however, does not impair the value of the work as a surgical guide, since the sugar-tests are given at length in many familiar textbooks. The size of the volume allows very thorough discussion of all practical points in genito-urinary surgery.

*A Hand-book of the Diseases of the Eye and their Treatment;* by HENRY R. SWANZY, A. M., M. B., F. R. C. S. I., Surgeon to the National Eye and Ear Infirmary and Ophthalmic Surgeon to the Adelaide Hospital, Dublin. Fourth



edition, with 176 illustrations. 8vo.; pages 518; cloth \$3.00, leather \$3.50. Philadelphia, 1892: P. Blakiston, Son & Co., 1012 Walnut St.

This handy volume is one of a series of Student's Manuals issued by Blakiston. That it has reached its fourth edition is sufficient proof of its excellence and popularity.

The present edition has been thoroughly revised and brought up to date. An appendix deals with Holmgren's method for testing the color sense, and is accompanied by a test-plate of colored worsteds. A second appendix deals with the Irish military color tests, etc.

### **Pan-American Congress.**

#### **MANIFESTO OF THE SECTION ON OTOLOGY.**

Honorary Presidents: Drs. Adolf Alt, St. Louis, Mo.; Albert H. Buck, New York; Gorham Bacon, New York; Wm. Cheatham, Louisville, Ky; Francisco de P. Chacon, City of Mexico; Sebastian Cuervoy Serrano, Sancti Spiritu, Cuba; J. C. Connel, Toronto, Canada; Stephen Doge, Halifax, Nova Scotia; J. B. Eaton, Portland, Oregon; A. A. Foucher, Montreal; John F. Fulton, St. Paul; J. Wilford Good, Winnipeg, Manitoba; Francis B. Loring, Washington, D. C.; Henry D. Noyes, New York; Arturo Costa Pruneda, Santiago, Chili; Charles Inslee Pardee, New York; G. Sterling Ryerson, Toronto, Canada; D. B. St. John Roosa, New York; W. H. Sanders, Mobile, Ala; Belisario Sosa, Lima, Peru; G. C. Savage, Nashville, Tenn.; J. J. B. Vermyne, New Bedford, Mass.

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The Section of Otology has been rendered necessary by the fact, that while the treatment of diseases of the ear has in the past been mainly in the hands of ophthalmologists, the recent advances in the study of diseases of the nose and pharynx has necessarily divided the practical work of treatment of the diseases of the ear; so that at present we find these diseases considered by both ophthalmic and rhinologic surgeons. It is hoped that in this section surgeons of both classes may meet, and to this end the effort will be made to secure hours not conflicting with either of the other sections.

Communications in reference to papers should be addressed to the English-speaking Secretary, Dr. Max Thorner, 141 Garfield Place, Cincinnati, O., sug-



gestions as to work and exhibition of instruments to the Executive President, Dr. C. M. Hobby, Iowa City, Iowa.

### Medical Progress.

#### TWO CASES OF CÆSAREAN SECTION.

On February 8th, Dr. Herman operated at the London Hospital. The case was one of extreme rickety deformity. Labor had come on at the end of the eighth month of pregnancy and the liquor amnii had escaped. The uterus was opened while within the abdomen and pressed out of the wound after the child had been extracted. The uterine wound was closed with eight interrupted silk sutures, passing through the muscle but not through the decidua, and a fine continuous catgut suture of the peritoneum. The child was living, and at the date of our last report (Feb. 14th) both mother and child were doing well in every respect. In order to sterilize the patient both Fallopian tubes were tied. A loop of one was tied and cut off; the outer half of the other was ligatured and removed. The second operation was performed at St. Thomas's Hospital by Dr. Cullingworth on Feb. 9th, on a patient aged thirty-one, suffering from rickety pelvis, with an estimated conjugate diameter of  $2\frac{5}{8}$  inches, and pregnant for the seventh time. Three of her previous pregnancies had terminated in miscarriage and one in labor at term, when craniotomy had to be performed. On two occasions labor had been induced at seven months; the first time the child lived a few hours, the second time the patient was in the General Lying-in Hospital in York-road, where delivery was effected by version, followed by perforation of the aftercoming

head. On again becoming pregnant she was advised to go to full time and be delivered by Cæsarean section. To this she eventually consented. The operation was performed a few days before labor was expected. Labor had not commenced. The uterus was opened *in situ* and the child extracted before the liquor amnii had been allowed to escape. The child, a well-formed male,  $7\frac{3}{4}$  lbs. in weight, cried vigorously as soon as it was born. The placenta and membranes were quickly removed. There was a little delay owing to the uterus not contracting well; but the amount of blood lost was not very great. No elastic ligature was used. The outer inch of both Fallopian tubes were removed in Dr. Cullingworth's case, as this had proved to be necessary by a case which occurred four weeks ago at Guy's Hospital, and which showed that mere ligature is insufficient when they are simply ligatured in continuity. The uterine wound was secured by six deep and about as many half-deep silk sutures. The operation lasted fifty-five minutes. Except that the patient vomited for a few hours during the latter part of the second day her recovery has been as satisfactory as if after a normal confinement, the highest temperature having been  $99.4^{\circ}$ .—*Lancet*.

#### A NEW HYPNOTIC DERIVED FROM CHLORAL, BUT WITHOUT THE DANGEROUS PROPERTIES OF THE LATTER.

In the *Comptes Rendus, etc., de l'Académie des Sciences*, 1893, vol. cxvi, p. 63, we find an interesting note by Hanriot and Ricket on a new derivative of chloral which they call *chloralose*. The same substance, they say, was prepared by Hefter and described by him (*Ber. d. d. ch. Gesells.*, 1889, p. 1050), but, as

claimed by Hanriot and Ricket, in an impure state. Chloralose is prepared, according to Hanriot and Ricket, by heating glucose and chloral, from which results, on cooling, a pasty mass. From this mass, by a somewhat lengthy process, they obtain chloralose; the yield being three per cent.

As finally obtained, pure, the chloralose crystallizes in fine needles slightly soluble in cold water, moderately soluble in warm water and in alcohol. They fuse at 184-186°. On heating, these crystals volatilize completely without decomposition, and on analysis, they correspond to the formula  $C_8H_{11}Cl_3O_6$ . Treated with potash it does not give glucose (contrary to Hefter's statement concerning the substance which he analyzed). With sulphuric acid we obtain a di-sulphuric compound, and with acetic anhydride a compound containing four acetyl groups.

As the result of experiments on dogs, cats and bisds, *as well as on themselves*, and also *after five month's trial in hospitals* by Landouzy and Montard-Martin, Hanriot and Ricket feel justified in stating that in chloralose they have a hypnotic which, while inducing sleep, does not depress the spinal cord, and is without the dangers of chloral. It induces refreshing sleep without unpleasant after-effects. It is more powerful than chloral and can be given in a smaller dose.

As a result of clinical experience in the hospitals, one gramme ( $15\frac{1}{2}$  grains) was found to be a large dose. The best results were obtained in doses of from 0.20 gr. to 0.80gr. (about 3 to 14 grains). The usual dose given was 0.50 gr. (about 8 grains).

In these doses it is not only hypnotic but also analgesic, so that it is highly recommended when pain is to be quieted as well as when sleep is to be induced.—Dr. Kemp, *Brooklyn Med. Jour.*

#### MORE YEARS OF STUDY, OR MORE STUDY IN THE YEAR.

In view of the fact of the sharp and continuous lessening of the percentage of college-bred men entering upon medical studies, the cultured editor of the *American Lancet* suggests that the terms of undergraduate medical study be continued almost or quite throughout the entire year. Thus the alumnus would come to practise at about twenty-five years of age. The lengthened term of study in literary and scientific institutions must certainly become an established fact. It is felt that long vacations are, in great part, useless gaps of leisure and that they do not harmonize with the press and rush of the world that is round about, or that is to come. As a medical study, the five or six months semester, and the six or seven months of vacation are already nearly the wonder of the past. To lengthen the term to nine, ten, or even to eleven months, would not be without good consequences. It would perhaps stop vacation loafing, weed out the unriper students, bring to medical study those better fitted, financially and educationally, increase the number of professional teachers, limit the power of the commercial professor as well as that of his college, and thus centralize and dignify the science and the art of medical teaching.—*Med. News.*

#### THE PREVENTIVE TREATMENT OF TETANUS.

Dr. T. W. Simmons, of Hagerstown, Md. (*Med. News*), states that it is our

duty to kill the tetanus bacilli while they are yet confined to the point of introduction and before systematic infection has occurred. He regards this as simple and feasible and recommends the following method of procedure in all cases of punctured wounds, which removes all possibility of danger, and besides has the advantage of relieving pain and soreness and promoting rapid healing of the wound: He removes all foreign substances from the wound, and thoroughly cleanses the surface about it with a probe or olive-pointed hypodermatic needle made of gold, about two inches long, and something larger than an ordinary hypodermatic needle. With this needle attached to an ordinary syringe, he injects into the wound, if painful or sensitive, a four per cent. solution of cocaine, which is allowed to remain until its full effects are produced. He then draws out what may remain within the wound, and with the same instruments injects the following:

R.—Argenti nitratis. . grs. v.

Aquæ. . . . . 3 ss.

Or,

R.—Hydrarg. chloridi corrosivi . grs. ij.

Acid carbolici. . . . . grs. xv.

Alcoholis. . . . . 3 ss.

—*Inter. Jour. of Surgery.*

#### GUAIACOL SALTS IN TUBERCULOSIS.

Of drugs advocated for the treatment of pulmonary and other forms of tuberculosis, creasote is one of the best. Its only equal, indeed, is iodoform. Some patients, however, possess or acquire an intolerance (subjective or objective) to creasote, whatever method of administration be tried.

In such cases, guaiacol carbonate or guaiacol benzoate may be advantageously substituted. These are unirritating and

almost tasteless. The dose of either salt is from 3 or 5 grains (0.2 to 0.35 gram) up to the point of tolerance. An effective dose is 5 grains, four times a day best given in capsule or cachet after food. As guaiacol benzoate is split up in the small intestine into benzoic acid and guaiacol, it seems to have an especial advantage in the treatment of intestinal lesions, and is certainly quite useful in the management of diarrhœa in tuberculous subjects.—Dr. Solis-Cohen, *Medical News*.

#### TREATMENT OF HÆMORRHOIDS BY ELECTROLYSIS.

Dr. J. B. Bacon (*Milwaukee Medical Journal*), employs the following method, which in all of his cases caused a decided decrease in the tumors, without secondary hæmorrhage, sloughing or after-pains. He makes use of an instrument consisting of a long pair of forceps similar to urethral forceps, insulated with vulcanized rubber except at a place about one-half inch long on the face of the blades. On the handle of the forceps is a set-screw to fasten to the positive pole of the battery. The hæmorrhoid is seized with the forceps in such manner as to have the exposed metal of the blades clasp it at its base, when it can be steadily held, or drawn down so as to expose it to view while operating. The negative pole is connected with a disk or needle holder, preferably one containing four needles. After grasping the hæmorrhoid with the forceps, a few drops of four per cent. solution of cocaine are injected into the tumor; after a few minutes waiting for the anæsthetic effect of the cocaine, the needles are pushed into the center of the tumor and an assistant turns on from five to ten milliamperes of current. Immediately



there will be noticed an escape of hydrogen around the needles, and a decided blanching of the hæmorrhoids. The current should be kept up until the tumor becomes a whitish-gray color, usually requiring from two to five minutes time.

The current between the electrodes cauterizes by electrolytic action the tissue composing the tumor, resulting in its ultimate absorption.

There are some points necessary to observe in using electrolysis in this class of cases.

1. Give an enema and thoroughly empty the colon before operating.

2. Disinfect the tumor before introducing the needles, and again after the operation.

3. Never use this method in acutely inflamed hæmorrhoids.

4. Do not use over one-sixteenth of a grain of cocaine hypodermically.

5. Always insert the needles into the tumor before the current of electricity is turned on, and have the assistant again turn the current off before withdrawing the needles.

6. Use a milliampere metre for measuring the strength of current, as it is impossible to estimate the varying resistance of the tissues in different cases.

7. The needles may be a direct source of infection in the hands of a careless operator, and they must be boiled before using.—*International Journal of Surgery.*

### Medical Items.

More than five hundred thousand cases of cholera occurred in Russia during the epidemic of 1892.—*Med. Rec.*

The attempt noted in this issue of a number of the younger ministers of the

city to bind together in some form of organic union the forces which make for good in the community is highly commendable. We hope that every society of whatever name or creed will be invited to send delegates to the proposed convention, and that medical societies, which are great forces for good, will give a ready response to the invitation.

County Commissioners Magruder and Weis, who made a sanitary inspection of Canton and Highlandtown, in company with Dr. E. E. Jones, sanitary officer of the county, report that a very bad condition exists, especially at Canton. The streets and alleys need cleaning and in many places garbage and other refuse are thrown out into the highways. Dr. C. W. Fehlfenfeld, sanitary officer at Canton, was directed to notify property-holders to clean their premises.

The annual session of the State Medical Faculty has been this year an unusually successful one. We hope to give a full account of it in an early issue of the JOURNAL.

We are pleased to see that there is an increasing sentiment in the Faculty in favor of considering this Journal its official organ; and we hope the day will soon come when *all* of its papers and discussions shall be given to us for publication. Some of the papers are already in our hands and will be placed before our readers at the earliest opportunity.

The faculty of the College of Physicians and Surgeons announces the following appointments for the ensuing year: Dr. Standish McCleary, resident physician at the City Hospital; Dr. C. F. Blake, first assistant; Dr. Thomas H. O'Connor, second assistant; Dr. Marshall H. Bailey, third assistant; Dr. H.

H. Haydn, resident physician at Bayview; Dr. Sylvan H. Likes, assistant; Dr. C. S. Neer, resident physician at Maternite Hospital; Dr. James A. West, a sistant in insane department, Bayview. —*Sun.*

The Alumni Association of the University of Maryland School of Medicine adopted resolutions governing the endowment fund provided for the school. The fund is to be put in the hands of nine trustees to be elected from the association. Three trustees are to be selected from the association, two from the faculty of physic, one from the faculty of law, and three at large. The fund is to be administered for the benefit of the school of medicine and no portion of the principal can be spent. The trustees are required to form a corporation and to elect a president, secretary and treasurer and an executive committee, with power left to the trustees to fill all vacancies. An annual report must be made by the trustees. The trustees selected are: Dr. Henry M. Wilson, Dr. Charles O'Donovan and Dr. Eugene F. Cordell, from the Alumni Association; Thos. W. Hall, from the faculty of law; Dr. Samuel C. Chew and Dr. J. Edwin Michael, from the faculty of physic; Frank Frick, Richard McSherry and Lawrason Riggs, at large. —*Sun.*

A large proportion of the Protestant clergymen of Baltimore attended a special meeting of the Ministerial Union at the Y. M. C. A. Hall last night to consider the union of all the moral forces of the city. Rev. Hiram Vrooman read a paper on the subject, after which, by a series of resolutions, the Ministerial Union determined to attempt to organize the moral agencies of Baltimore, and to call a

general conference of moral workers, which is to consist of three delegates from each society or organization interested. The union also authorized the committee, which arranged for last night's meeting, to make arrangements for the general meeting to be held about one month hence.

Mr. Vrooman, in his address, said: The tendencies most noticeable in our age augur evil, and should urge us to greater sacrifice, but in the tendency which is less apparent and which looks to the unification of christendom lies the hope for the future. This is the age of large cities. The recent discussions relating to city problems have pointed out clearly that our large cities not only possess controlling power over the nation, but are gaining more influence continually. That the drift of the cities is the drift of the nation is no longer disputed.

"We observe that in the cities the saloons, gambling dens and brothels multiply and the churches do not. The lower elements control the politics; and great slum districts, filled with disease, poverty and crime, spread over great territories while the interests of purity are neglected.

"These evil tendencies that are so glaring in New York, Chicago and other cities are in rapid progress here in Baltimore. As yet they are not so marked, but the conditions for their advance are becoming more favorable each year.

"Including Catholic, Protestant and Jewish, there are about 370 churches in Baltimore, while there are 2,100 saloons. This is one house of worship for about 1,350 persons, and one saloon for about 235, including men, women and children. Nearly 50 per cent. of our school children are growing up illiterate. Slum districts are beginning to form." —*Sun.*

# MARYLAND MEDICAL JOURNAL.

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### Original Articles.

#### REMARKS ON THE TREATMENT OF DIPHTHERIA OF THE FAUCES.\*

BY CHARLES O'DONOVAN, M. D.,  
OF BALTIMORE.

I know of no subject in the domain of medicine that has made a greater or more satisfactory advance during the past few years than the etiology and treatment of diphtheria, and in this advance, each in his own field, both the pathologist and the clinician may claim equal rights; the former for having settled forever the much discussed problem of the local or constitutional origin of diphtheria; the latter for having decided upon the treatment best adapted to meet the solved problem. How many weary hours have I not wasted

in endeavoring to satisfy myself which was right, before the researches of Loeffler and others led the way to what is now the accepted theory of the causation of diphtheria and decided that the Klebs-Loeffler bacillus was the sole cause of true diphtheria, that the disease is primarily local, but that the toxic ptomaine produced by the bacillus passes so rapidly into the organism and there so rapidly overwhelms the nervous system of those resisting badly that what is usually local becomes apparently a constitutional disease. In spite of the many pseudo-bacilli and the other confusing details, the central fact makes the course of the disease so clear, and its treatment so simple and distinct, though not always efficacious, that we practitioners would do well to accept it and prepare to work upon it, leaving to the bacteriologist

\*Presented to the Medical Journal Club, April 8th, 1893.



the elaboration of the minor accidents. Until the winter of 1890-91 I was amongst the constitutionalists. I believed that croup and diphtheria were identical, each being a development in a different locality of a false membrane as the result of a systemic infection not well understood in its nature, but appalling in its results; as such I treated my cases and with the saddest outcome; so much so that there was no disease in the whole list that I feared more than diphtheria. My treatment was the best that I could find according to authority, but I made the great mistake of giving first importance to the constitutional disturbance and watching the throat secondarily, holding that as the disease was checked in the system the throat would of itself get well. I used the tincture of iron, quinine, whiskey and small doses of calomel frequently repeated, and for the throat a carbolic acid spray; good treatment now as far as the internal medicine goes, indeed the best that I know of, but the spray should have been the first and most important member of the group, and instead of the inert carbolic acid should have been some agent capable of removing the nidus in which the bacilli were living and producing the deadly poison under which the victims were surely sinking. In Sajous' Annual for 1889 is a very full and exact article on diphtheria from Dr. J. Lewis Smith, introducing the abstracts of which he is editor; it makes very interesting reading now, especially when compared with the article by Drs. J. Lewis Smith and Warner in the same annual for 1892; the former being expressive of the doubts of the author groping after the truth, the latter his acceptance of the

theory of the causative power of the Klebs-Loeffler bacillus. In the matter of treatment the advance has been equally marked, but entirely in the local treatment. In the *Brit. Med. Jour.*, of Sept. 22, 1888, Dr. A. Jacobi gives his course of internal medication as, in a few words, rest in bed, full doses of tincture of iron, free and early use of whiskey and other heart tonics if required, as digitalis, strophanthus, sparteine, camphor, alcohol and musk, and the exhibition of fair quantities of bichloride of mercury well diluted is water or milk. This is the treatment of to-day as well as five years ago, and I doubt the existence of any better, but the local trouble demands attention in even greater degree than the systemic effects. Five years ago the throat would have been sprayed or washed with solutions of carbolic acid, lime water, lactic acid, sodium hyposulphite, chloral hydrate, sodium carbolate, salicylic acid, bichloride of mercury, turpentine, menthol, sodium borate, also with oil of eucalyptus and other so-called antiseptic vapors and sulphur in powder. I have myself in desperation used sprays of these inert substances without deriving a particle of benefit from most of them, and but trifling good from the few that seemed at all to affect the membrane. As the opinion spread that the local trouble was the true source of the disease clinicians turned more seriously to the study of the effect of various sprays on the membrane, and then it was that efforts were made to digest the membrane and so destroy it; efforts with pepsin, trypsin, papoid, papayotin and many other substances were indulged in by more or less enthusiastic workers, but with indifferent success; they were now-

ever on the right track. In May 1891 I first used hydrogen peroxide in diphtheria, in one of the worst cases of faucial diphtheria that I have ever seen; the membrane had appeared during the second day of the boy's illness on the left tonsil, which it speedily covered and within twenty-four hours both tonsils were completely hidden; within forty-eight hours the entire pharynx was covered with the membrane, which had also covered the pendulous palate, extended into the naso-pharyngeal cavity to an indefinite extent in spite of vigorous treatment. It was suggested by Dr. John N. Mackenzie in consultation, that hydrogen peroxide be used every two hours, day and night; the full strength of Marchand's solution was liberally and accurately applied by the spray to the whole surface then invaded, and also to the nasal cavity through each nostril. However the boy lived through his attack was a mystery to both of us, unless it was that his age, about 14 yrs., and his perfect health and strength before his illness enabled him to stand up under a load that few could carry.

Day after day we fought the membrane from May 7th until the 17th, when it finally disappeared from the throat, during which time it had covered the parts already mentioned, and extended at times over half of the roof of the mouth and over a large portion of the mucous membrane of the left cheek, as well as appearing at both nostrils from above; it showed no disposition to travel toward the trachea. At each time that his throat and nose were sprayed great quantities of pultaceous matter were dislodged and he would express his satisfaction. The total amount discharged

was enormous, yet in two or three hours the membrane would be again as tough and ugly-looking as before. During the entire time he was treated very freely with calomel, so that his bowels were discharging several times each day the characteristic stools. He was very well fed and whiskey was administered freely. As his throat grew better, tincture of iron was added to the other medicines. This extremely interesting case, after passing through the severity of the attack with a fine pulse and appetite, developed weak heart after the diphtheritic membrane had entirely disappeared; he passed out of my hands about the 27th of May, was treated by several of our best physicians, but died about three weeks later of weak heart. I have not since had a death from diphtheria.

When called to see a child with sore throat it is often extremely difficult to say whether it is or is not diphtheria, but experience will enable one usually to estimate the severity of the case; if doubtful one should be on the safe side and prepare for serious trouble: restriction to bed, a quinine suppository to reduce fever, calomel in small doses frequently repeated until bowels move once, milk diet, with a little whiskey, makes a good course of preliminary treatment no matter what is to follow. If at the next visit the appearance of the child's throat is worse and its general condition no better, with some induration of the glands at the angle of the jaws, and if the patches on the tonsils show tendency to spread, diphtheria may be strongly suspected, and the spray should be at once begun. In very young children it is often impossible to spray the fauces satisfactorily and in those



cases a mop or swab may be used as a substitute, though never by preference. The solution that I use is equal parts of distilled water and hydrogen peroxide. I think it makes little difference which brand of peroxide is used; all are likely to spoil if kept, and even when kept as carefully as possible; but it is extremely important to have the spray used at first in your presence, so that you may instruct the nurse how to use it, and also to notice whether or not the peroxide is of good quality, for if it is not active it will do no good whatever, and valuable time will be lost in a false sense of doing what is right for the patient. It has happened to me twice during the past winter that the solution dispensed, once by one of the best druggists in Baltimore, was useless, and I was fortunate enough to discover it and have it rectified before harm had resulted. In one case the clerk showed me a fresh bottle from which it had been the first taken, but the solution had decomposed before he opened the bottle and was inert; another bottle from the same stock was tried and proved to be all right. If you have never used the peroxide in these cases, you will be astonished at the result of the spraying. The membrane rapidly softens and disintegrates, allowing its ready expulsion in a white, slimy expectoration; if the child is old enough to help you by voluntarily opening the mouth wide, you can see the membrane dissolve before the spray and melt from the mucous membrane. Unfortunately it is rapidly reformed in the commencement of attacks, the newly planted colonies of bacilli appearing to possess a wonderful vitality and power of reproduction, but the spray must be kept up every two or

three hours until the bacillus wearies, as it were, of the struggle and you find the membrane reformed less and less rapidly and of less consistency after each spraying; then you can see hope before you, and may feel sure that your case will recover if the proper systemic treatment has been carried out at the same time. It may be that, in spite of repeated spraying with peroxide, the membrane reforms so rapidly or extends so that the life of the patient is in jeopardy, calling for more energetic measures still; these I would supply by a spray of corrosive sublimate (1 to 2000) in addition to the peroxide spray, using the latter first for its property of disintegrating the envelope of membrane, and then the former as a direct antiseptic, applied as close as may be to the bacilli exposed by the former spray. I have so far had no occasion to use this method of treatment but I consider it as near the ideal local treatment as we have arrived at present. The first principle of constitutional treatment in this, as in all debilitating diseases, is strict rest in bed; this should be insisted upon, and the child should not be allowed to leave bed until, by careful observation, one is sure that the heart is sufficiently recovered to be able to properly perform its functions, for it is upon the heart that the toxic effect of the diphtheritic poison is exerted in an especial manner. Many cases have been lost after apparent recovery, from no other cause than that permission had been given too soon to leave bed.

Of all the medicines recommended for internal administration in diphtheria I prize most highly alcohol, given in this disease in heroic doses. I have seen its good effect upon the weak rapid heart



too often not to have learned its value; in mild cases, even, I give it from the start and continue it throughout the illness and even through convalescence; the amount given should vary with the intensity of the attack and the age of the child; for a child of two years a dessert-spoonful of whisky in water or milk every three hours may be considered a minimum dose in severe cases; watch its effect on the pulse and your experience will enable you to proportion your whiskey to meet the severity of the disease. I give always, in these cases, calomel in small doses quite frequently, say a twelfth of a grain every half of an hour, mixed with sugar or bismuth or some inert powder; this is stirred in a little water and given regularly, and as many of the doses as can be so arranged are given just after the spray has been used, for I believe that a great deal of the good effect of the mercurial is derived from its local action; particles of calomel becoming caught in the membrane already disorganized and softened by the peroxide, and then changing into bichloride, passing into solution in the tissue and so producing an antiseptic action far stronger than usual while in the nascent state. Whether this theory contains any truth or not, I rank calomel next to alcohol in the systemic therapeutics of diphtheria, giving it in small doses until the characteristic stools have been produced, then enough to keep the bowels a little loose until convalescence is established. I do not agree with those who give calomel in this disease in heroic doses, nor with others who keep the child's bowels running all the time like green frog-spawn. I think that the drain is too severe and that it tells later against the child when he needs all the strength that he can reserve. I know, for I have seen it, that children show a remarkable tolerance of large doses of calomel in this disease, but I consider it bad practice, and I never use it in this way. I can only explain it by thinking that the bowels become tolerant and refuse to absorb the drug, which then passes through as an irritating, or at best an inert mass. The food also must be carefully attended to; happily children with this disease usually take food well; it should be liquid by preference, as less apt to injure the inflamed throat; milk and its preparations forming the best of all foods; if milk be distasteful, or the child tire of it, its use may be suspended for a while and resort had to one or another of the innumerable prepared foods now on the market. Mellin's or Ridge's food is well taken by the children. "Malted milk" is another excellent preparation, or a broth of beef, mutton or chicken may serve as an appetizer. These, however, are only expedients; milk is the best and most nourishing food for a sick child; if the stomach is weak, digestion may be aided by pepsin in a suitable mixture; or if the calomel produces griping pains its use may be suspended for a short while; all these indications must be met as they arise. So far I have said nothing of what was formerly considered the "sheet anchor," tincture of the chloride of iron. I am convinced now that this drug has no place whatever in the battle with diphtheria at the outset; the frightful pallor that we have all seen, that seems to deepen while we look at the sufferer, is a profound toxæmia, a breaking up of the blood-constituents by a virulent poison

entering the blood from without, manufactured by the bacilli in their habitat in the membrane and passing, by osmosis, perhaps, into the blood; how useless is it to pour into the stomach the tincture of iron in the vain hope of building up the blood-corpuscles, in the presence of this overwhelming poison! Let us rather remove, by peroxide of hydrogen, the armor of membrane behind which the bacilli work in safety, washing away at the same time myriads of their fellows and weaken the army left behind; let us endeavor to annihilate what is left of them by mercury, which is poisonous to their existence; returning again and again to the attack as long as one colony remains to form a settlement capable of increase; let us sustain our patient with good food, and stimulate him with alcohol until their murderous attack shall have abated and then, in the stage of convalescence, when fear of poisoning or suffocation shall have passed, and the constitution, free from taint, but enfeebled by the struggle, begins to call for a tonic, then and not till then, is iron imperatively demanded, and then the tincture should be given. Let it be given in small doses at first, cautiously increased as the system becomes more and more able to assimilate it, and great good will be derived from its use.

This brief outline covers the essentials of the treatment of diphtheria; certain accidents and sequelæ require special treatment, but of them I will not speak at present. If the treatment outlined be followed I think one may count on a fair proportion of recoveries; it has certainly given excellent results in my practice.

### ENDOWMENT FUND OF THE UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE.

At the annual meeting of the Alumni Association of the University of Maryland School of Medicine, held on the 18th instant, the following resolutions were adopted without dissent:

*Resolved:*

I, That the Endowment Fund already provided for shall be placed in the hands of a Board of Trustees to be elected by this Association.

II, That the said Board shall consist of nine persons, as follows: three from this association, one from the Faculty of Law, two from the Faculty of Physic, and three at large, and this shall be the permanent composition of the Board.

III, That the said Board shall receive, invest and control, at its discretion, the Fund, for the exclusive benefit of the School of Medicine, with this limitation, that no portion of the principal of said Fund be expended.

IV, That the members of the said Board shall, as soon after their appointment as convenient, proceed to organize and elect officers, viz.: a President, a Vice-President, a Secretary and Treasurer, and an Executive Committee, and shall secure letters of incorporation under the laws of the State.

V, That the said Board shall have power to fill vacancies in its membership, whether due to death, resignation or any other cause.

VI, That the first members of the said Board shall consist of the following:

Dr. Henry M. Wilson, Dr. Charles O'Donovan, Dr. Eugene F. Cordell, representing this Association,



Mr. Thomas W. Hall, representing Faculty of Law.

Dr. Samuel C. Chew, Dr. J. Edwin Michael, representing Faculty of Physic.

Mr. Frank Frick, Mr. Richard McSherry, Mr. Laurason Riggs, at large.

VII, That the said Board shall make to this association annually a report of its trust.

VIII, That the Committee on Endowment be continued and directed to proceed to the further execution of the duties imposed upon it by the resolutions of 1892.

The "Endowment Committee" consists of Drs. Cordell, Chew, Hopkinson, Michael and Martenet. The appointment of an independent Board of Trustees to manage the financial affairs of the school, and the other details given are heartily approved of by the Faculty of Physic. Mr. Frick, of the above Board, is the President of the Board of Trade, and a brother of the late distinguished Professor Charles Frick, of the University. Messrs. Riggs and McSherry are both graduates of the Law School of the University, and the latter also a son of the late Professor Richard McSherry.

### Society Reports.

#### REPORT OF THE 22ND CONGRESS OF THE GERMAN SURGICAL ASSOCIATION, BERLIN, 1893.

REPORTED FOR THE MARYLAND MEDICAL  
JOURNAL BY DR. WM. ERNST  
MILLER.

The twenty-second German Surgical Congress met April 12, 1893, in the large and handsomely arranged Audito-

rium of the Langenbeckhaus on Zeigelstrasse. Every chair was occupied by members of the Congress, and the gallery filled with numerous guests, among others of Germany's more prominent surgeons present were the following: König, of Göttingen, Esmarch (Kiel), Czerny (Heidelberg), Bardenheuer (Köln), Küster (Marburg), Trendelenburg (Bonn), Bruns (Tübingen), Wagner (Königshütte), Gussenbauer (Prague), Helfrich (Greiswald), Mikuliez (Königsberg), Fischer (Breslau), Kraske (Freiberg), Von Bardeleben and Von Bergmann (Berlin), Schede and Lauenstein (Hamburg).

The session was opened by President König, who delivered an appropriate and very interesting address, directly after which the programme for the day was taken up in the following order: Von Bergmann (Berlin) on the extirpation of a tumor of the liver, a malignant glandular or adenomatous nature, about the size of a child's head; the tumor was demonstrated, also the patient, who had recovered within five weeks of the operation. W. Müller (Aachen) then read an interesting paper on Non-Parasitic Cysts of the liver, with demonstrations of several preparations; both speakers agreed that these operations are not as serious as has been generally supposed, and as soon as the technique becomes more perfected, the prognosis will be also much more favorable. Hoffa (Würzburg) then related his method of treating congenital hip-joint subluxations, which consists in an incision being made into the joint, and the tendons stretched, some even cut through if necessary, and the head of the femur replaced in the acetabular cavity. König admitted the su-



periority of this operation over the one recommended by him, which differs essentially in that the head of the femur remains in its abnormal locality.

The annual report on anæsthetics, which is collected yearly by the association, was now read by Gurlt (Berlin); fifty-eight observers had returned reports to his inquiries. In all 57,541 anæsthetizations; of these, 11,464 made with nitrous oxide gas must be left out of consideration.

In a total of 157,815 anæsthetizations made during three years, fifty-three deaths had occurred. Of the various anæsthetics, the proportion of deaths is as follows:

With chloroform, 1 to 2,899.

Chloroform and ether, 1 " 4,118.

Bromide of ethyl, 1 " 4,538.

Pental, 1 " 199.

Making an average of one death to 2,900 anæsthetizations. No deaths had been reported from ether alone. There seems to be a general leaning in Germany towards ether at present, although there are some, such as König and Bardeleben, who still prefer chloroform. In the discussion which ensued, König recommended for cases of cardiac failure from chloroform narcosis, not too heavy but rhythmical blows over the region of the heart.

Helferich (Greiswald) next demonstrated his new method for the treatment of ankylosed knee-joints, by bow-shaped resections, and Bier (Kiel), his method of amputation according to which the lower part of the stump is bent at a right angle to the leg, forming a kind of foot arrangement, to which an artificial limb can be applied and adjusted without causing pain, as is usual from pressure on the stump.

Next Küster (Marburg) and Wolff (Berlin) read papers on their methods of treating cleft palate. While Wolff believes it is preferable to operate early even in the first months of infancy. Küster holds that the proper age is between 5 and 7 years. The first day's session closed by Czerny (Heidelberg) bringing forth his method of removing the uterus through an opening made in the sacrum, although he seems to have had but little success with this operation, he claims considerable for it in the way of simplicity and comparative ease with which it can be carried out.

#### SECOND DAY'S SESSION.

This was opened by Heinleth (Hamburg) demonstrating a new thoracometer and Karg (Leipsig) glass-micro-photograms of pathological preparations, which were remarkable for the accuracy with which they were executed.

Next, Hahn (Berlin), demonstrated a patient, a man 35 years of age, who had been in perfect health previously, but addicted to alcoholic excesses, when he noticed a gradual impairment of vision, which finally resulted in a complete loss of sight of one eye. To this was added loss of memory and a continuous dull pain in the head. Cysticercus was at once thought of, and an operation concluded upon. A square-shaped piece of bone was removed from his frontal region, whereupon the dura mater came into view and appeared extremely tense. After opening the same a considerable portion of cerebral substance protruded, and it being impossible to return it, was excised, but at once more bulged forward. It was thought this phenomenon must be due to intraventricular pressure. A long hypodermatic needle was thrust into the

ventricle and about 100 c.c. of fluid withdrawn; the protruding cerebral substance went back completely and the wound thoroughly closed. The patient made a complete and satisfactory recovery with the exception of loss of sight in one eye. That cysticercus was the cause of the trouble could not be definitely decided, but probably the excessive indulgence in alcoholic drinks may possibly have been the causative factor.

Nicolai, Frankfurt, a O) presented a patient who had been accidentally injured by the prong of a pitch-fork having been driven through his left parietal bone. The patient was rendered unconscious for the time being; the wound was enlarged, cleansed of all particles of filth and foreign bodies, as far as could be discovered, whereupon healing ensued. However, there was noticed afterwards a right-sided hemiplegia with loss of memory and some slight symptoms of aphasia. The wound was cut down upon and after a thorough investigation a spicule of bone was found wedged into the brain substance; the same was carefully removed, after which all the above-mentioned symptoms disappeared and the patient made a complete recovery.

Stenzel (Cüstrin), then reported a case of trephining for fracture at the base of the skull with hæmorrhage. And F. Krause (Altona), cases in which he had treated ulcers of the leg by flaps of skin transplanted from the arm; while Lauenstein (Hamburg), presented a patient on whom he covered a large destruction of tissue of the face by skin taken from the breast, a pedicle being allowed to remain for a time.

Then Schede (Hamburg), followed with a demonstration of an improved

apparatus for the the treatment of severe "scolioses." And Schlange (Berlin), with two cases of abnormally high position of the scapulæ, the spinal column being perfectly normal.

Schulze-Berge (Oberhausen), demonstrated a patient on whom he had performed stretching of facial nerve for the cure of trigeminal neuralgia. Although the resulting deformity of the face is frequently extreme, the speaker has thought it wise to introduce this method, the other operation being rather severe for the treatment of this malady.

Köerte (Berlin) closed this session with a report of a case of choledochotomy for gall stones, upon which he had successfully operated.

#### THIRD DAY'S SESSION.

Was opened by demonstrations by Krunkenberg, (Halle a S), of apparatuses for the treatment of joint contractures. And Bart (Marburg), Kümmell (Hamburg) on kidney resections and Schede (Hamburg), preparations, showing the advantage in the use of deep-seated silver wire sutures for laparotomies and radical operations for hernia. The preparation showed that the sutures become imbedded without causing any irritation whatever. Then Schimmelbush (Berlin), presented two interesting cases of tracheal defects. After tracheotomy in cases of diphtheria this loss of substance, or defect frequently results, and often to such an extent that complete loss of voice occurs. In the first of these cases, a girl of 9 yrs. in whom a large piece of tracheal wall about 4 inches in length was wanting, phonation had been entirely impossible; the child herself however discovered a means finally of remedying this evil which consists in bringing her head well for-



ward and downward towards the sternum; she manages in this way to close the opening and thus speaks quite clearly. The second case, a girl 13yrs. of age, was especially difficult to treat inasmuch as the loss of structure was here even greater; the following operation however was determined upon and performed: A portion of her sternal periosteum was secured and placed in the defect, whereupon effectual healing soon ensued. The child who, with this malady, could not for ten years produce a sound, is now able to speak properly. Next in order came Von Eiselsberg (Vienna), with a report of his experiments on the total extirpation of the thyroid body in sheep. The results showed that these animals remained exceedingly small and were psychically undeveloped, showing that their vegetative functions were deficient and far from normal. Neuber (Kiel), then spoke on asepsis and the methods of producing bloodlessness in surgery; he claims advantage in the use of moistened linen bandages for this purpose, over that introduced by Esmarch. Von Bramann (Halle a S) now read a paper on the treatment of gunshot injuries of the abdomen. He claims that within the first twenty-four hours laparotomy should be performed, and that greater delay is dangerous to the patient.

Sonnenburg (Berlin) then demonstrated preparations of bone-filling which has recently come into surgical practice. The method of using plaster for this purpose is objectionable inasmuch as antiseptics cannot be carried out sufficiently. He has therefore employed amalgam fillings of cement and copper; the results of this method have been exceedingly satisfactory. Von Bramann (Halle a S), con-

cluded this session, by reading a paper on the treatment of large defects of skin and soft parts, by means of transplanting flaps of skin to which pedicles are allowed to remain for a time. He demonstrated several cases; all were severe and in which amputation had to be considered; the parts injured were mostly hands for which the flaps were secured from the breast, the rest for those of the foot were taken from the leg of the sound side; the results obtained were very satisfactory.

#### FOURTH DAY'S SESSION.

This, the last, was opened by a paper read by Schimmelbush (Berlin) on the disinfection of wounds. In order to investigate what influence pathogenic organisms have on the surface of open wounds, and whether it is possible to destroy these by disinfection, the following experiments were carried out by him. Cultures of anthrax bacilli were placed in the wounds and disinfection at once undertaken; notwithstanding however the use of the strongest materials for this purpose, it was impossible to prevent general infection in any case. The infection into and throughout the tissues takes place with such rapidity that by disinfection immediately after inoculation it is not possible to destroy all organisms. And if the same culture were injected in the tails of mice, general infection also ensued, notwithstanding the amputation of same ten minutes thereafter.

Messner (Munich) next spoke of the bursting of cold tubercular abscesses of the thorax parietes into the lungs or bronchi, and Von Bramann (Halle a S) on pulmonary emphysema following injuries.



Gleich (Vienna) then addressed the meeting on the operative treatment of flat foot. In Billroth's clinic he pursued the following method with success. The calcaneum is sawn slantingly from behind forward; the inferior portion is then carried forward and allowed to heal in this position; although the limb becomes somewhat longer by this method the function of the foot is restored.

Bart (Marburg) then spoke of the histological changes of bone implantation. According to his investigations, the implanted portion, even if healing takes place, does not regenerate, but dies, and merely serves as a mechanical framework upon which new osseous material is deposited.

Among others, Bork (Rostock) spoke on obturator hernia, Köerk (Berlin) on gall-stone obstructions of the bowels; Köhler (Berlin) on a case of hip and knee joint resection performed successfully at one operation; and Wohlgemuth, (Berlin), of a new tracheotomy canula with demonstration.

With the election of Esmarch as President for the coming year and cheers to the health of the presiding officer König, the meeting closed.

#### TYPHLITIS.

At a recent session of the Harveian Society of London (*Lancet*) Dr. Treves discussed the Pathology of Typhlitis and certain points in its clinical aspect. He pointed out that the majority of cases of typhlitis recover under medical treatment, and that only a certain proportion of the cases of relapsing typhlitis call for operation. Before operating in the relapsing form one or other of the following conditions should be present: (1) The attacks are numerous; (2) they are increasing in

frequency and severity; (3) the last attack has been alarming; (4) the patient is rendered an invalid; (5) there is evidence of pus about the vermiform process; (6) in every case the enlarged appendix should be capable of being demonstrated during the quiescent period. Mr. Treves then described the details of the operation and concluded by giving a description of fourteen cases of removal of the appendix for relapsing typhlitis which had been under his care, all of which recovered.—Mr. EASTES considered that the cases usually seen by the members of that Society were of a less serious character than these described by Mr. Treves, but that the treatment required for those milder cases was equally definite and should consist of absolute rest in the recumbent posture, semi-starvation, liquid diet alone, and the use of an opiate with some belladonna to prevent constipation.—Mr. CRIPPS LAWRENCE mentioned having treated cases, one some six years ago, with anti-rheumatic remedies, with marked benefit.

#### KNEE-CHEST POSITION IN LABOR.

Dr. Middleton writes to the *British Med. Journal*: Some time ago I was called to a woman in labor; she had employed an ignorant neighbor to conduct the birth, and the result was that when I arrived I found a leg and arm presenting, the placenta partially detached, pretty sharp continuous hæmorrhage, and, of course, practically all the liquor amnii escaped. I tried at first to turn the child with the mother lying on her side, but did not make much headway, so decided to adopt the knee-chest position. This seemed to act like a charm, and to my great satisfaction I delivered the fœtus (dead) in a very short time by the breech,

## MARYLAND MEDICAL JOURNAL,

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A. K. BOND, M. D., Editor.

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BALTIMORE, MAY 6, 1893.

**Editorial.**THE COLORED DEAF IN  
MARYLAND.

We have received a circular from the School for the Colored Blind and Deaf-Mutes.

This school, located at 649 W. Saratoga St., Baltimore, is now under the supervisory care of Mr. F. D. Morrison.

It was organized in 1872, for the purpose of instructing the deaf, dumb and blind colored children of the State. Its organization was authorized by the State, and it is supported by State appropriations. Its management is intrusted to the Boards of Directors of the "Maryland School for the Deaf and Dumb," and "the Maryland School for the Blind," and its methods of instruction and training are modeled after those institutions. Every provision has been made here for the education of every deaf and dumb or blind colored child in the State, free of all expense to the parents, except for clothing.

It is a school, and not an asylum or home. The school session commences on the 15th of September, and closes on the 20th of June. All deaf and dumb or blind colored children, between the ages of 9 and 16 years, who have sufficient capacity (mental and physical) to receive instruction, and are free from contagious diseases or fits, may be admitted on application to the superintendent of the institution. The Board of Directors feel that the advantages of this school have not been properly appreciated by the colored people of the State, which is no doubt owing to their lack of knowledge in regard to it.

We regret to learn that the same advantages are not offered alike to the white and colored deaf in this State. We are informed that lip-reading is taught only to white patients, while in the colored schools, which are said to be "conducted on the same plan," and are under the same general control, only finger language is taught, the excuse being that training in lip-reading is too expensive.

The deaf child sent to this colored school is therefore exposed to the danger of becoming dumb as well; whereas, if lip-reading were taught, as in white schools, he might preserve his power of speech and be enabled to converse easily with his fellow-men whenever there was sufficient light to see the lips.

It is a pity that Maryland is too poor to be able to rescue her deaf colored children from the sad life of the deaf-mute.

Mr. D. E. Stauffer, Jr., the intelligent gentleman in charge of the Maryland Colored School, writes that there is no lip-reading school for the colored in the United States.

We fear that the "champions of the oppressed" who figured so boldly at and just before "the war" have lost their early enthusiasm for "equal rights."

### THE *LANCET'S* REPORT ON CHICAGO WATER.

We are sure that all Americans appreciate the interest which this great British journal has taken in appointing a commission to examine the water-supply of Chicago.

We do not deny the right claimed by the *Lancet* of knowing something about the fluid which is to be supplied to the guests of the great Exposition under the name of "water."

The *Lancet* is to be commended both for the minuteness of its investigations, and for the generosity which prompts it to take the most favorable view of the combination water-cistern and sewage-tank of that great metropolis.

The readers of the report will be impressed with the energy shown by Chicago in the race between lengthening water-supply pipes and extending sewage deposits; and likewise in its endeavor to send its offal and filth down the Mississippi to be used as drinking water by the cities along its banks.

The *Lancet's* report is full of information, but, as regards practical deductions, we find that it only confirms the previous impressions of persons acquainted with the Chicago water-supply; namely, that when the tide is unfavorable the citizens drink partly diluted sewage; and that when it is favorable, they drink questionable lake water which has traveled a long distance in sewage-coated pipes.

We fear that the temperance move-

ment, so much needed in American cities, will meet with a serious set-back in Chicago this year.

There will doubtless be manifested, by visitors to the Exposition who have regard for their digestive organs, a strong tendency to lodge in some suburban place which has a supply of pure water from spring or artesian wells, and to visit Chicago daily by train; being careful not to drink the city water, and even looking with suspicion upon the liquids sold under the label of "mineral water."

### Reviews, Books and Pamphlets.

*Fermentation, Infection and Immunity; a New Theory of these Processes which unifies their Primary Causation and Places the Explanation of their Phenomena in Chemistry, Biology and the Dynamics of Molecular Physics*; by J. W. McLAUGHLIN, M. D., Austin Texas. E. von Boeckmann, Printer, Austin, Texas, 1892. 8vo., pp. 240. Cloth.

This is a philosophical excursion into the misty land of molecular activities. As the mere existence of the atom and molecule are theoretical, of course systems of speculation as to the relation of their movements to the causation of fermentation, immunity and disease rest on still more nebulous foundations.

As a specimen of the contents of the book we select the following: "Any bacterium is pathogenic to an organism when the molecular wave-vibrations of this bacterium coincide in periods and time with those of the albuminoid of the organism."

*An Introduction to the Study of Diseases of the Skin*; by P. H. PYE-SMITH, M.



D., F. R. S., Physician to Guy's Hospital, etc. Philadelphia, 1893: Lea Brothers & Co. Svo., pp. 408. Cloth. Illustrated.

This hand-book is a reprint, with additions, of chapters on diseases of the skin, written to complete Dr. Hilton Fagge's work on medicine.

It is based on the personal observations made by the author while in charge of the department for cutaneous diseases in Guy's Hospital. There are some outlines, exhibiting by dashes of red, the distribution of certain of the diseases of the skin.

*Elementary Physiology for Students:* by ALFRED T. SCHOFIELD, M. D., Late House Physician to the London Hospital. In one 12mo. volume of 380 pages, with 227 engravings and 2 colored plates containing 30 figures. Cloth, \$2.00.

A handy and profusely illustrated hand-book chosen with due reference to the needs of the practical worker.

### Medical Progress.

#### STOLTZ'S OPERATION FOR CYSTOCELE.

Reporting a number of illustrative cases, Dr. Napier (*British Medical Journal*) April 8th writes as follows concerning it.

*Method of Operation.*—Having the patient placed in the dorsal position, with the knees well flexed and the labia separated by assistants, I introduce a sound within the bladder, and displace the viscus as far downwards as possible. I then seize the anterior vaginal surface with vulsella or catch forceps, and drag it downwards. A superficial circular incision, varying with the size of the cysto-

cele, is marked out. A large Hagedorn needle, held in a holder, and bearing a stout silk thread, is introduced half an inch below the meatus and slightly to its right side; the needle is carried round outside the marked line of incision, and the suture is kept as much buried as possible; it finally emerges to the left side of the point of entrance. The denudation is then made with a scalpel, commencing usually at the margin near the meatus and terminating at the line nearest the cervix. When the tissues are non-cicatricial and loose, the handle of the scalpel or finger will easily separate the greater part. Should there be any threatening of hæmorrhage, slight tightening of the ligature, by raising the ends of the thread, not drawing on them, controls it. It is very rarely necessary to apply catch forceps; and inadvisable, unless really requisite, as I think it lessens the chance of accurate adhesion of the denuded surface. After finishing the denudation, the sound is withdrawn from the bladder, and, having thoroughly bathed the raw surface with perchloride of mercury solution, a clean sound presses the denuded part upwards and inwards. The circular ligature is pulled tight and firmly tied. Should there be any puckering at the edges of junction, showing raw surfaces, two or three fine chromicised catgut stitches are introduced. The silk thread is left *in situ* ten or twelve days, when it is removed, or may then be cut short near the knot, and allowed to come away of itself. In some cases of cystocele I have supplemented Stoltz's operation by a plastic operation on the posterior vaginal wall and perineum. For operators unaccustomed to Hagedorn's needles, a handle needle, curved

on the flat and with posterior notch for reception of the thread, may be found more manageable.

*The Advantages and Results of Stoltz's Method.*—The advantages of this modification of Stoltz's original operation are: 1. The amount of tissue to be removed can be more accurately determined. 2. No hæmorrhage obscures the field of operation. 3. No retraction of tissue occurs, as happens when denudation is effected before introduction of the ligature. As to the results of the operation Munde says, "In no case have I seen the cystocele return after this operation." Dr. Heywood Smith, in reply to my inquiry, informed me that since publishing his first case, he has only done Stoltz's operation two or three times. He has seen it "fail to heal properly, but then it granulates well and produces some contraction." He adds, "I still think it a good operation, as it takes shorter time than most of the others, and I should try it again."

#### INOCULATION OF MEASLES.

Reporting in detail nine cases in which the experiment was tried, Dr. Thomson, of Glasgow (*British Medical Journal*, April 8th), says: That of nine cases in whom inoculation was practised, the first and second appear to have been rendered immune; the third, in whom the disease was incubating, seems to have had the attack decidedly modified; the fourth, also, who had been strongly exposed to infection for a considerable time, had the disease in a mild form; the fifth, in whom both local and general effects were much the same as in the first two, appears likewise to have been rendered immune. The sixth, having been said to have had previously a

mild attack of measles, may be eliminated altogether. In the seventh both local and general effects seemed *nil*, possibly owing to the inoculated matter being weak, and the child took the disease in the ordinary form when exposed to infection. In the eighth the local effects were unusually slight, and although on the fifth day he was feverish, there was an absence of the specific symptoms of measles. He also took the disease on exposure to infection. In the ninth the local effects were more marked than in No. 8, with an entire absence of general symptoms, yet, though living with him, he escaped the disease. Out of the eight cases, after eliminating No. 6, four appear to have been successful in preventing the disease, two in modifying the attack when inoculation was performed during the incubative stage, and two to have failed. As in these latter two the local effects were unusually slight, it is possible the matter was too weak.

One word as to the choice of the matter and the mode of inserting it. I would recommend, first, that each of the blisters to be raised for procuring the matter should not be larger than a measly patch, and the matter should be used with as little delay as possible; and secondly, that it should be inserted by superficial scarifications or punctures made obliquely under the epidermis with a sharp "broad-shouldered" lancet, keeping the skin upon the stretch in such a manner as not to draw blood during the performance of the operation. Whether the bacilli found in the blood of the patients affected with measles by Drs. P. Canon and W. Pielicke, of Berlin, be the real pathogenic germs has not been finally determined, but if it were possible to obtain a pure culture of the



germ of measles, doubtless that would form the best material for inoculation, but until that has been procured the matter from small blisters would be worth trying. That it is an attenuated virus seems probable, and should be used as strong as possible.

#### LEPROSY IN INDIA.

The full report of the special commissioners appointed to investigate the subject of leprosy in India contains interesting facts. The alarm about an abnormal increase of leprosy in British India is, the report says, not based on fact. The figures suggest a decrease rather than an increase. In round figures, taking the areas enumerated at all three censuses, the numbers have changed from 100,000 in 1871 to 105,000 in 1891, the ratio being approximately 5.0 per 10,000 for each census. There seems to be some connection, accidental or otherwise, between the dampness of climate and the prevalence of leprosy, and it appears that in those areas where cholera is epidemic leprosy is especially prevalent. There is also some evidence that leprosy is most prevalent in the most poverty-stricken areas. Altogether the commissioners attach great importance to poor and unsanitary conditions, bad social surroundings and so forth, as factors in the etiology of the disease. The native population is the most prone to the disease, and the unmixed European least. The report fails to find any justification for the attempt to establish any connection between the spread of leprosy and the practice of vaccination. The commissioners declare that "leprosy in India cannot be considered a hereditary disease, and they would even venture to say that the evi-

dence which exists is hardly sufficient to establish an inherited specific predisposition to the disease by the offspring of leprosy parents to any appreciable degree." They adduce forcible arguments against the existence of a true specific hereditary predisposition causally related to the leprosy in the parent, and conclude that marriages among lepers and with lepers do not increase the risk of a diffusion of leprosy by means of the offspring. They say that though leprosy must be classed among the contagious diseases, yet the risk of contagion is so small that it may practically be disregarded; and the attention of the reformer or legislator should therefore be directed toward the removal of predisposing factors.—*Sun*.

#### MYELOMA OF TENDON SHEATH.

This case is one of tumor of a tendon sheath. Apparently simple in character, it presented a structure after removal and examination under the microscope which proved it to be of unusual composition. The patient was a female servant aged seventeen, who was admitted into the Royal Free Hospital under my care on November 12, 1892, complaining of a swelling of the first finger of the right hand. There was nothing of importance in the family or previous history of this patient; she had noticed a swelling in the situation of the tumor for the past five years and it had gradually increased to its present size. It had not caused her any pain, but was inconvenient as it interfered with the use of the hand. On the flexor surface of the first phalanx of the index-finger of the right hand was a tumor about the size of a chestnut, not very hard, but firm in consistence and containing two



hard nodules. Somewhat oval in outline, it extended from the first interphalangeal joint to the palm, and bulged equally to the sides. The tendon was quite free and the finger movable. The tumor could be moved from side to side, but not in the long axis of the finger. It did not appear to grow from the bone and was not at all sensitive. It was considered to be a soft fibroma having its origin in the tendon sheath. On the 14th, it was removed through a longitudinal incision along its flexor surface. The superficial part was easily separated, being encapsuled, but it was more difficult to get the growth away below. It had, as we rightly supposed, its origin in the tendon sheath, some of which had disappeared in the tumor, while in another part dense bands from the sheath passed into it and assisted in holding it down. A prolongation of the tumor extended round the tendon and completely encircled it. The tumor was also adherent to the fibrous tissue of the sheath on each side of the tendon, and these attachments had to be cut away, there being nothing to mark the point at which the tumor ceased. After its removal about half the tendon lying over the first phalanx was exposed in the wound. Only one or two small vessels required to be ligatured, and the wound, which was closed with silk sutures, healed by first intention. The finger for a fortnight was swollen at the seat of operation on account of some effusion of blood into the wound, but movement has been permitted, which does not cause pain, and she can fully flex and use her finger, the only sign of anything abnormal about it being the presence of some thickening and a linear scar. The tumor is a lobulated soft growth in the greater part, but presenting two or three areas of yellowish change, and of harder consistence, resembling cicatricial tissue. The prolongation which encircled the tendon is of softer growth and more vascular and can still be seen to form a tunnel with the main growth, through which the tendon passed. Examination under the microscope shows the tumor to consist mainly of fibrous tissue, but scattered through the section are a number of well-marked myeloid cells. Tumors containing myeloid cells such as that described here are very rare, if one may trust the published reports of microscopical examinations, and it is very interesting to find that such cells may be found in growths which have no connexion with bone or periosteum. Fibrous tumors of the tendon sheaths, from which these cannot be distinguished clinically, have frequently been brought before the Pathological and other societies, but I can only find an account of one myeloma in English literature. In a paper by Mr. Makins on some intra-bursal growths, read before the Pathological Society in November, 1886, he refers to a specimen which he removed from the tendon of the middle finger of a girl of twenty. It was of three years' growth, not painful when pressed upon, and on removal looked like a typical hard fibroma. It reached to the posterior aspect of the sheath and was removed without baring the tendon. On section he found scattered myeloid cells. More recently Mr. Heurtaux, in an account of these myelomata, has given five cases, three of which had been under his care.—Dr. Battle, *Lancet*, April 8th.

TROPHIC CHANGES DUE TO THE PRES-  
SURE OF A CICATRIX IN THE PALM.

Wounds of the palm of the hand in-

volving injury of important nerves are not infrequent. The case to which I now draw attention simulated wound of the median nerve in the palm very closely, and the hand exhibited trophic changes commonly seen after the normal innervation of a part has been seriously interfered with. A watchmaker aged forty-eight came under my care on January 20th, 1890, complaining of numbness and tingling in the fingers and thumb of the right hand. Four months before he had broken a glass vase by striking it against a clock with the palm of the right hand. There was considerable hæmorrhage, and one piece of glass was removed from the palm of the hand at the time. The wound healed readily. There was then no impairment of sensation or motion. A month later he was pushing some furniture when the scar gave way and bled; a small piece of glass protruded and was extracted by the man himself. A month after that he found the hand getting stiff, and he began to have numbness and pins-and-needles in it and this had been steadily increasing since, so that the man had not been able to follow his occupation. Examination of the right hand showed some swelling of the fingers evenly distributed; the skin looked more shiny than on the other hand and the furrows were a good deal smoothed out. Over the distal phalanx of the first finger there was a good deal of swelling, and on the anterior surface were three sores, the two lower being covered with dried secretion; from the upper one serous fluid exuded on pressure over the top of the finger, where there was a large blister. The skin of this upper part of the first finger was discolored and bluish. The thenar em-

inence was wasted. The patient complained of numbness and occasional pins-and-needles in all the fingers and in the palm for about an inch, the more proximal part being normal and the transition from the normal to the abnormal area being gradual. Only the front and tip of the last joint of the first finger were absolutely insensitive. There was a small scar between the thenar and hypothenar eminences an inch below the wrist; immediately below this scar there was a slight prominence, and when this was pressed, especially if pressure was directed outwards, the patient complained of tingling in the fingers and pricking at the point of pressure. Four days after admission an incision about two inches and a half long was made over this scar in the line of the median nerve, commencing about half an inch above the wrist and continued into the palm. A good deal of very dense cicatricial tissue was met with at the lower border of the annular ligament, but no glass or other foreign body was found. The annular ligament was divided, and the median nerve, especially the palmar enlargement and the branches from it, carefully examined. It appeared quite normal; it was considered, however, that the palmar enlargement was more flattened than it should have been; and as the most dense part of the cicatrix corresponded in position with it, a piece of the scar tissue was removed from each side of the incision. About six fine silk ligatures were required for small vessels. The annular ligament was united by four deep silkworm-gut sutures and the superficial part of the wound by interrupted silk sutures, in the usual manner. No drainage-tube was used.



The wrist was semiflexed and placed in an anterior splint.

Eight days after the operation a slough was found at the end of the index-finger. The wound healed by first intention, and when the man left hospital on Feb. 8th, the sores on the index finger were healed. He presented himself once at a later date; the skin was then recovering sensation in the parts previously numb; the sores had quite healed and the color of the first finger was becoming the same as that of the others. There can be little doubt that the trophic changes in the hand were due to compression of the median nerve by the cicatrix which followed the wound of the palm. The gradual onset and steady increase in severity of the changes until, and for a time after, the operation point to this conclusion, which is further confirmed by the result of the operation.—Dr. Battle, *Lancet*, April 8.

#### CYST OF FLEXOR SHEATHS OF FINGERS.

In the London *Lancet*, April 8th, Dr. Battle relates a case of tendon-sheath cyst in which two more like those seen about the wrist developed on the flexor surfaces of the index and middle fingers. The patient was sent for my opinion as to the advisability of submitting to amputation of the end of the right forefinger on account of a lump which had been painlessly growing in the pulp for a period of six months and which was still increasing in size. She thought it had commenced in the skin, for it was movable at first, but lately it had become more fixed. There was a rounded, fluctuating swelling which caused a uniform enlargement beyond the line of the last inter-phalangeal joint, and was quite fixed, tense and fluctuating. This I con-

sider to be a cyst possibly connected with tendon sheath.

Gas was administered and a lateral incision gave exit to glairy fluid; the cavity, lined by a glistening membrane, contained no growth and extended deeply to the periosteum. It was washed out with a carbolic solution and firmly wrapped with a strip of gauze. Ten days later she told me that she thought there was another swelling in a corresponding position in the middle finger; this was so, and similar treatment, without anæsthetic, was carried out. Both these cysts were cured by this treatment.

#### NOTIFICATION IN GERMANY.

The German Government have under consideration a Bill for the notification of infectious diseases. The draft in its general lines is similar to our own Notification Act, but differs in some essential points. The notifiable diseases are cholera, typhus, yellow fever, Oriental bubo plague, smallpox, puerperal fever, typhoid, diphtheria (including croup), relapsing fever, dysentery, and scarlet fever. The notification is a dual notification—that is, the duty is imposed both on the doctor in attendance, and on certain persons belonging to the family or having care of the patient. With regard to cholera, typhus, plague, and small-pox a suspected case would have to be notified. The notification is made to the district authority and to the official physician, who, for the purposes of this article, may be conveniently called “the health officer.” The health officer has the duty of investigate any outbreak of the infectious maladies named; and possesses extensive powers of entry, and so forth; for example, if necessary a *post mortem* examination may be ordered by the police authorities on the requisition



of the health officer. On the police authorities of the district rests the primary duty of taking precautions in epidemic times; but in emergencies it is proposed to give the health officer power to order at once necessary precautions without waiting for the action of the higher authority. Persons ill of the notifiable diseases and homeless or without fixed abode are to be detained in one place. Travellers coming from places in which cholera, typhus, plague, yellow fever, or small-pox prevails are to report their arrival to the police. Persons suffering from infectious diseases may be ordered to be isolated; the isolation may be in the person's own house, but if that is impracticable he is to be removed to hospital. Regulations as to school attendance, the closing of suspected water supplies, regulations for the disposal of the infectious dead, for compensation for objects destroyed and a number of similar details are contained in the Bill. A new feature is a clause providing that, should there be a threatened outbreak of infectious maladies of the eyes, the government can order medical treatment of the sufferers. Punishment for infringing the proposed code is to be of a drastic character. Transmitting knowingly clothes infected by most of the notifiable maladies is punishable by imprisonment up to two years, but a money fine (1,500 marks or less) may under certain circumstances be substituted for the imprisonment. Other offences against the statute are punishable by heavy fines. *Brit. Med. Jour.*

Dr. Melvin S. Rosenthal, who for the past year has been assistant resident physician at the City Hospital, has been appointed resident physician at the Hebrew Hospital.

### Medical Items.

Dr. A. K. Bond has removed his offices and residence to 889 Park Ave., between Biddle and Howard Sts.

The publishers of the *Ontario Medical Journal* receive a subsidy of \$600 a year from the College of Physicians and Surgeons, in return for furnishing all members of the College with the journal.

According to the *Sei-I-Kwai Med. Jour.*, the returns of the recent census show that in Tokyo, Japan, there are 7,023 persons over 80 years of age, 5,783 over 85, 205 over 90, 13 over 95, and 4 over 100.

Dr. R. F. Gundry, in charge of the Richard Gundry Home at Catonsville, Md., has opened a city office at No. 1 East Centre Street, where he can be found regularly on Mondays, Wednesdays and Fridays of each week, and any other day by special appointment.

The German Anatomical Society will hold its annual meeting this year at Göttingen, from May 21st to 24th, under the presidency of Professor Waldeyer. Among the communications promised are the following: Professor Toldt, of Vienna, "History of the Mesenteries;" Professor Schwalbe, Strassburg, "Ending of the Nerves in the Organs of Special Sense."

Baron Albert Rothschild has given half a million florins for the purpose of founding a hospital for the treatment of persons suffering from cancer. It is understood that the gift is intended to commemorate the death of the late

Baroness, who, it will be remembered, died from cancer.

The faculty of the Woman's Medical College, of Baltimore, have announced the graduates for this year and the successful contestants for prizes. The graduates are: Anngenetta L. Fowler, Ida Pollock, Elizabeth Renshaw, Tertia Claire, L. Wilton, Belle J. Platt, Edith Eareckson, Fannie E. Hoopes and Mrs. Sophie L. Woods. Miss Fowler won the gold medal and Miss Pollock the practict prize.

At the request of the Indian Government, the organizing Committee of the Eleventh International Medical Congress to be held at Rome next autumn has decided to establish a subsection of the Section of Hygiene to discuss the whole subject of Asiatic cholera, to study its origin, the means of arresting its diffusion, and its treatment. Professor Cunningham will, it is believed be chosen to represent the Indian Government at the Congress. The Governments of Peru, Paraguay, Colombia and Ecuador have expressed their intention of sending delegates to the Congress.

The Johns Hopkins Library has received an important gift from Dr. Ferdinand E. Chatard, of Baltimore, consisting of the medical library of his father, the late Dr. Ferdinand E. Chatard, Sr., who died in 1888. The gift contains several hundred volumes of well-known professional works, including several volumes of considerable rarity. The university library already possesses the nucleus of a valuable medical library in the gifts of Drs. Chris. Johnston and Francis Donaldson, and the collection of Dr. Chatard will be added to it.—*Sun.*

Dr. Charles D. Jefferson, one of the best-known physicians on the Eastern Shore, died at his late residence, in Federalsburg, very suddenly of heart trouble, April 27. Dr. Jefferson was born at Church Creek, Dorchester county. He was sixty-two years of age. He studied medicine under the late Dr. Carroll, of Cambridge. He accumulated considerable wealth by his business and close attention to his profession. Thomas O. Jefferson, druggist, and Dr. H. Kemp Jefferson, physician, both of Federalsburg, and Charles Jefferson, an engineer on the Baltimore and Ohio Railroad, are his brothers.

The Committee on Health heard arguments for and against an ordinance providing that no glue factory, stockyards or places for rendering grease from dead animals shall be constructed or rebuilt within the city limits under a penalty of \$500. Health Commissioner McShane advocated the ordinance. He spoke of continually recurring complaints from persons in the neighborhood of soap factories, slaughter-houses and fertilizer works, and said that the health department repeatedly notified the proprietors of such factories to abate nuisances which are caused by offal. He said that if the nuisance is abated upon notice, a similar nuisance frequently arises in the course of a few weeks. Mr. Joshua Horner, Jr., president of the American National Bank, opposed the ordinance, and urged that power be given the health commissioner to secure clean premises around such factories. The matter was not determined by the committee.

The American National Committee, Eleventh International Medical Congress, to be held at Rome Italy, Sept. 24th

to Oct. 1st, 1893: W. T. Briggs, Nashville, Tenn; H. P. Bowditch, Boston, Mass.; S. C. Busey, Washington, D. C.; C. Cushing, San Francisco, Cal; N. S. Davis, Chicago, Ill.; Norman W. Kingsley, D. D. C., N. Y.; Wm. Osler, Baltimore. Wm. Pepper, Philadelphia, Pa.; E. Peyre Porcher, Charleston, S. C.; Charles A. L. Reed, Cincinnati, O; D. B. St. John Roosa, New York; Alex. J. C. Skene, Brooklyn, N. Y.; James Stewart, Montreal, Can; A. Jacobi, 110 W. 34th St., New York, Chairman.

The North German Lloyd, 2 Bowling Green, N. Y., offers a reduction of 25 per cent. to the medical men going to and coming from the 11th International Medical Congress, on steamer Werra, which is to sail from New York on August 5th and September 9th, and on steamer Fulda, August 19th. Both these steamers sail to Genoa. The same reduction will be made for the return trips in October and November, on the same steamers, and for the Company's (Saturday off Bremen, Sunday off Southampton) steamers.

The Hamburg-American Packet Co., 37 Broadway, N. Y., 125 LaSalle Street, Chicago, offers a reduction of 25 per cent., both out and return, for all its steamers during the year 1893.

The Compagnie Generale Transatlantique, 3 Bowling Green, N. Y., offers the rates which are allowed French officers, that is, \$63.50 for an \$80 accomodation \$91.50 for a \$120 accommodation.

Five other lines decline to make any satisfactory arrangements.

The American Association of Obstetricians and Gynæcologists will hold its sixth annual meeting at the Russell House, Detroit, Mich., on Thursday,

Friday and Saturday, June 1st, 2nd and 3rd, 1893, under the presidency of Dr. Lewis S. McMurtry, of Louisville. The following is the preliminary programme as far as titles are announced: The President's Address, The Present Position of Pelvic Surgery, by Dr. L. S. Mc Murtry, of Louisville; Abdominal Fixation, by Dr. Florian Krug, New York; Endoscopic Tubes for Direct Examination of the Interior of the Uterus and Bladder, by Dr. Robert T. Morris, New York; Placenta Prævia, By Dr. William H. Wenning, Cincinnati; What are the Indications for Abdominal Section in Intra-Pelvic Hæmorrhage? by Dr. M. Rosenwasser, Cleveland; Treatment of Metritis, Dr. E. Pietranera, Cordova, A.R.; A Contribution to the Pathology of Surgical Disease of the Gall-Bladder, by Dr. Walter P. Manton, Detroit; The Legal Question in Gynæcological Operations on the Insane, by Dr. Walter P. Manton, Detroit; Pelvic Abscess, by Dr. L. S. Stone, Washington; Central Rupture of the Perineum; Its causation and Prevention, by Dr. John C. Sexton, Rushville; A case of Myomectomy with Extra-Peritoneal Treatment of the Pedicle, followed by Pregnancy and Complicated by Hæmorrhages through the Abdominal Cicatrix, Dr. X. O. Werder, Pittsburg; Anatomy and Surgical Importance of the Peri Renal Cellulo-Adipose Tissue, by Dr. L. H. Dunning, of Indianapolis; there will also be about twelve other interesting papers read at the meeting.

A cordial invitation is extended to the members of the medical profession interested in the work of the Association to attend its several sessions. W. Warren Potter, Secretary.



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### Original Articles.

#### SUBCUTANEOUS EMPHYSEMA; WITH A CASE COMPLICATING MEASLES.\*

BY J. S. FULTON, M. D.,  
SALISBURY, MD.

Mary T., aged eight and one-half years, was seen on the morning of February 25th, 1893. There was a history of five days' sickness; the last three in bed. An abundant eruption of measles was present; a troublesome cough, rapid breathing (respirations 50 per minute) and a temperature of 104°. Except as to cough and dyspnœa, no complaint was made. Slight delirium had been present at intervals for about twelve hours. Inspection of the fauces revealed the usual

hyperæmia of measles, and nothing more save a small quantity of tough yellow matter hanging from the left posterior nostril.

Auscultation of the thorax discovered crepitant and subcrepitant rales upon both sides, very abundant and widespread throughout the right lung. No marked alteration of the percussion note was discerned. Diagnosis: catarrhal pneumonia, mainly of the right lung, complicating measles. Palpating the cervical glands, I found a small area of crepitation at the angle of the left jaw, and in the same region on the right side a similar but smaller effusion. The touch was unmistakably that of emphysema. The swelling was so slight that it would probably not have attracted attention, though the child was well-known to me. At my second visit in the afternoon the

\*Read before the Medical and Chirurgical Faculty, April 25, 1893.

delirium was continuous and the patient well-nigh uncontrollable. The temperature was  $105^{\circ}$  and the cough very harassing. The emphysema had extended well over the face, involving both eyelids, the cheeks, forehead and temples. The cellular tissues of the neck contained much air. The scalp was very little invaded except on the temples and in the cervico-occipital region. The emphysema continued to increase until Monday afternoon. At this time both eyes were closed, cheeks and temples ballooned out so far as almost to conceal the ears at a full face view. The neck was very large, but not tense. Half way down the sternum a ridge an inch or more in height from border to border of the pectorals formed the lower boundary of a very large collection of air. This elevation has been produced by the pressure of a wide bandage applied by the nurse to prevent disarrangement of the clothing and of the jacket beneath. Below this line the emphysema extended quite to the pubes. Indeed the crepitation was well-marked all over the trunk as far down as the pelvis. At both wrists the crepitation was very distinct, though less so at the right owing to dextro-lateral decubitus. The contour of the inflated parts was precisely similar to that resulting from anasarca, but the color and texture of the skin were not notably altered save at the margins of the eye-lids, especially at the inner canthus, where one saw the usual ecchymotic discoloration incident to obstructed circulation. Pitting upon pressure was very slight in this case, though the tension was not very high. The percussion note, wherever the amount of enclosed air yielded any tympany, was

that which one may elicit by immediate percussion of his own inflated cheek. The progress of the case was hopeful until Thursday morning in the small hours, when a violent exacerbation of the pulmonary symptoms occurred, the extent of the trouble in the left lung greatly increased, cyanosis appeared, the dyspnœa was augmented, there was incessant jactitation without return of cerebral symptoms, and the child died in the afternoon, about seven days from the inception of the lung trouble. No post-mortem.

Looking up this subject, we find in modern works very little reference to emphysema other than pulmonary. Before Laennec the term emphysema was applied only to pneumatosis of the cellular tissue, practically nothing being known of pulmonary emphysema. After his time the pathological condition of alveolar dilatation having become clinically recognized, the restrictive appellation, true emphysema, was applied to interlobular emphysema, manifestly a just distinction etymologically and historically. Osler holds true emphysema to be the condition resulting from distension, atrophy of the walls and fusion of air cells. So the process of time has warped the word entirely away from its original signification. Most surgical works contain some reference to subcutaneous emphysema, but in strictly medical literature it seems to be a neglected, as it is perhaps a relatively unimportant, topic. In Keating's *Cyclopedia of the Diseases of Children*, only Finlayson, in his article on general diagnosis, alludes to the condition, and then only to differentiate it from œdema. In Fagge's practice it is mentioned twice; once in con-

nection with a case of phthisis, and once in the article on pertussis. Flint gives the subject brief notice under the general head of pneumatoses. As a complication of measles, I have been able to find only the mere mention of a case by Copland, in his Dictionary of Medicine, a now antiquated work. It has been most frequently reported as a complication of pertussis; as might be expected, marginal emphysema of the lungs, the condition precedent to rupture, being seldom absent from the post-mortem findings of whooping-cough. Subcutaneous emphysema has also been reported as complicating occasionally the emphysema of the aged, sometimes diphtheria and scarlet fever, rarely phthisis.

Emphysema by chemical release of gas from the fluids of the body probably does not exist except in rapidly spreading moist gangrene. Nor is it ever due to any process analogous to secretion. Perhaps the nearest approach to such a phenomenon is found in the cystic disease of the vaginal mucosa which has been reported from time to time, and carefully studied by Winckel. The existence of idiopathic, or as it was once called, spontaneous intrinsic emphysema, has been quite gravely considered in modern times, and able men, hard pressed for clinical and pathological data, have traveled far afield in search of arguments from analogy. The air bladder of certain fish has been repeatedly adduced in support of the thesis that a process of secretion in the human body may yield gas as a product. It would be well, however, to pay a modest respect to this view, since so great a modern as Flint holds it, though somewhat tentatively.

An emphysematous condition is often seen about superficial wounds in some of the lower animals without gangrene and without suppuration. I have, myself, observed it in oxen and sheep, and at first sight it would appear that the gas must have been produced in situ. Both a purely mechanical explanation is at hand, though I do not know that its sufficiency has been verified. In cases of compound fracture surgeons have frequently noted subcutaneous emphysema as incident to long and rough transportation. Now, the animals in which this symptom occurs are abundantly supplied with small voluntary muscles whereby they are able to move limited areas of surface. It is their habit when wounded to keep the injured part in continual agitation, ostensibly for protection against the annoyance of insects. One can easily see that this incessant motion can, in the course of hours or days, aspire large quantities of air into the cellular tissues, the mechanical process being identical with that which accounts for the surgical emphysema above noted.

Experimental study upon animals of the phenomena of compression and decompression have pointed out a way by which subcutaneous emphysema might be expected to arise in man through chemical release of gas from the fluids of the body. One of the effects of high pneumatic pressure is supersaturation of the blood with the atmospheric gases, the oxygen alone entering into stable union. After sudden decompression a dog has been seen to become absolutely cylindrical from subcutaneous emphysema due to liberation of the uncombined excess. If such a phenomenon could occur in the human subject we should



observe subcutaneous emphysema as a frequent symptom if not a distinct variety of Caisson disease. No such observations seem to have been recorded, although the presence of gas in the blood is generally admitted, and one theory of the pathology of this affection rests upon the discovery of bubbles of nitrogen so set free in the spinal fluid.

The presence of air in the subcutaneous cellular tissues we shall therefore regard as always adventitious. It may result from a great variety of causes. Fractures of ribs are never considered without mention of subcutaneous emphysema. It is in fractures due to direct violence, perhaps a more frequent symptom than bony crepitus and in doubtful cases is held to be pathognomonic both of fractured rib and injury of the lung. Fracture of one of the thin bones of the inner orbital wall, perforation or rupture of the lachrymal duct or sac, or of the eustachian tube, may lead to emphysema of the orbit, or of the pharynx, the air being forced in by blowing the nose or by Politzerization. Emphysema of the face accompanies wounds of the antrum.

Exophthalmos is said to be fraudulently induced by inflation of the postorbital tissues. Like means are used to simulate hydrocephalus, hydrocele, hernia and dropsy. Auto-inflation of the head, neck and chest through a puncture inside the cheek has been seriously proposed as a means of escape from drowning.

In the case which serves me as a text, the origin of the emphysema was almost certainly an interlobular rupture communicating with the cellular tissues of the neck through the mediastinum. I

have alluded to the yellow matter in the fauces because for a moment one was ready to ascribe the very trifling emphysema to abscess perforation. The presence of a like manifestation in both parotid spaces dissolved this view. It might have been possible to trace the air to its entrance at the supraclavicular spaces if the distension could have been seen to increase there at the moment of cough, but this phenomenon was not noted.

Though this accident of subcutaneous emphysema was a clinical surprise to me, upon reflection one must wonder that it does not occur in a steady proportion of cases, the lobular pneumonia so frequent a sequel of measles being a contributory condition only less favorable to rupture than the emphysema of pertussis.

Very few autopsies appear to have been made upon such cases. The search that I have been able to make has unearthed but one and a mere abstract of that one. Hodge, in the *Glasgow Medical Journal*, of 1887, records a case, quoted in Sajous' Annual, of pertussis in which "an emphysematous swelling appeared upon the right side of the face and chest. It steadily extended to the left side of the face and of the chest, then over the whole trunk and upper extremities, then down both lower extremities, seeming to follow the course of the great vessels. At the autopsy the areolar tissue at the base of the lungs and anterior mediastinum were found infiltrated with air. Some pneumonia of both lungs with collapse of the left lower lobe. Large blebs were found over the surface of the lung and the subpleural tissue was infiltrated with air."

Theoretically one might expect serious consequences from pneumatic pressure in the mediastinum, containing as it does various important structures. It is said that the functional integrity of the phrenic nerve may in this way be so impaired as to gravely embarrass respiration, but no other untoward results have been noted as arising from the mechanical effect of the contained air. Ordinarily subcutaneous emphysema, unless the tension is uncomfortable, demands no treatment. Air which has been admitted through alveolar rupture of an otherwise healthy lung appears to be perfectly aseptic and is gradually absorbed. Of course the same may not be said of air which has entered through a septic passage; nor of the free air from without; nor of the gaseous contents of the stomach, which in cases of perforating ulcer produce subphrenic pneumothorax; nor of the bowels which in the same way give rise to peritoneal pneumatosis. Should the tension demand relief the means must be mechanical. The air is to be released by punctures through the skin. It is only practicable to relieve the tension in this way, as obviously no great amount of air can be evacuated unless through very numerous punctures. The procedure is only supplementary to the absorptive process. Whenever it is possible the access of air to the cellular tissues should be prevented by pressure properly applied at the point of entrance, but clearly such a measure is not one of our resources in a case due to interlobular rupture, as was that of Mary T.

A good physician can learn of a good location in a good part of Kansas by addressing Dr. S. W. Johnson, Admire, Kan.

AMPUTATION AT HIP-JOINT.  
 ENCYSTED CARTILAGINOUS TUMOR NEAR  
 SUBCLAVIAN  
 VESSELS.  
 OPERATION ON THE FIFTH  
 NERVE.

BY JOHN B. DEEVER, M. D.

Mr. President and Fellows of the Academy:—I will first present a case of amputation at the hip-joint, done for osteo-myelitis of the femur. At the time of the operation the patient was very much depressed from sepsis, consequent upon prolonged suppuration. The only point of interest in the case from an operative point of view is that during the amputation hæmorrhage was controlled simply by an Esmarch tube applied round the thigh, above the trochanter and along the crease of the groin, being retained here by two pieces of bandage, one passed beneath the tube in front and the other beneath the tube behind, each of which was held by an assistant. An oval flap of skin and fascia was made, and the muscles divided down to the bone by a circular sweep of the knife. The superficial and deep femoral arteries, with their accompanying veins, were next tied separately, as well as those of the muscular branches which could be recognized. The tube was next loosened a little, and the small vessels, as they bled, caught with hæmostats. The tube was now removed, and an incision carried from the external angle of the wound up over the trochanter and into the joint dividing the capsular ligament, when the muscles were carefully separated from the bone and disarticulation completed.

\*Read before the Philadelphia Academy of Surgery March 6, 1893.

The amount of blood lost, I do not think, amounted to more than two ounces. The advantage this procedure offers over the Wyeth method is in not dividing the femur before the disarticulation is made, and further, that the amount of blood lost is not any greater, and that the vessels not being constricted for so long a time, there is less likelihood of consecutive bleeding. The tumor I here present is one of sarcoma, removed from the side of the neck, which had its origin from the periosteum of the vertebræ. The symptoms presented by the patient were those of laryngeal obstruction, paroxysmal in character and attended by the expectoration of large quantities of mucus. The symptoms of obstruction were not caused by pressure inflicted upon the larynx or trachea, but from involvement of the laryngeal nerves. Before the operation was performed I very much questioned if the removal of the growth would suffice to relieve the obstruction, which was afterward proven by the same symptoms continuing until death, twenty-four hours thereafter. The dissection was not a very difficult one, as the mass lay behind the large vessels, the pulsation of which was scarcely perceptible. The great amount of infiltration around the vessels must by necessity have involved the laryngeal nerves as well.

The second specimen is one of cyst, in the wall of which is a circular piece of cartilage. It was removed from the subclavian region of a man who was injured at the battle of Appomattox, April 9, 1865. When the accident occurred he was standing under a tree. He was not able to say, definitely, whether the injury resulted from being struck by a piece of shell or by a piece of wood from

a tree. The only noticeable trouble at the time of the accident was fracture of the clavicle. From that time to the present a sinus has existed in the neck which patient states has been operated on without success. He was referred to me by Dr. Hildenbrand, when, upon examination, the orifice of the sinus was plainly to be seen immediately above the inner end of the left clavicle, from which was escaping a purulent discharge and through which, upon the introduction of a probe, could be felt, what was believed most probably, to be dead bone. Examination with the fingers demonstrated the presence of a partly movable mass which was thought to be a detached piece of clavicle which had undergone necrosis. Operation revealed the presence of this cyst; it was attached to the sheath of the subclavian vessels and to the pleura. Examination of the clavicle through the wound showed no trouble other than a slight enlargement at the seat of the original fracture. Examination of the cyst wall demonstrated very clearly the presence of cartilage.

T. M., aged fifty-eight years, white, Irish, slate-roofer; from a child had been very nervous, the slightest excitement or undue exertion throwing him into paroxysms of nervousness. When twenty-eight years of age, had an attack of smallpox which was followed by a weeping sore over the right inferior maxilla. This continued to discharge for six years, when it healed. Immediately after the healing of the sore he was attacked with neuralgic pains which were referred along the course of the inferior dental nerve. This pain continued at irregular intervals for six years, when he consulted a surgeon, who was supposed to



have removed a section of the nerve near the dental foramen. Very little, if any, relief followed this operation, when a second was performed by the same surgeon one year later; this was followed by relief for one year, when he had another attack of the pain. He now came under my care. I trephined the inferior maxilla over the angle and removed a section of the inferior dental nerve. This was followed by relief for a period of fifteen months, when the pain again returned. I now opened up the field of the old operation, exposed the proximal end (stump) of the nerve, excised a part therefrom, chiselled away the roof of the remaining portion of the dental canal, and removed the distal portion of the nerve as far as the mental foramen. This was followed by relief for sixteen months, when the pain returned, being referred, in addition to along the course of the inferior dental, along the side of the tongue. I now simply cleared out the field of the old operation, but this was not followed by any marked relief.

I again operated, this time taking out a vertical section of the ramus of the jaw as far as the sigmoid cavity, and removed a further section from the proximal end of the inferior dental, and at the same time a section from the gustatory nerve. This was followed by relief. I purposely refrained from taking a section from the inferior maxillary nerve immediately after it passes through the foramen ovale, also from performing an intra-cranial operation, as I am not as yet, by any means, convinced that these more radical procedures are warrantable until the milder ones have been done without success. I can recall a number of cases,

both of neuralgia of the inferior as well as of the superior maxillary nerve, where I have followed this course in relapsing attacks, with satisfactory results, to convince me that a longer period of relief from pain is offered the patient than would result, perhaps, by the more radical operations, removal of the Gasserian ganglion, etc., in the light of the present statistics.

#### AN UNDESCRIBED CAUSE OF DYSTOCIA.

In a paper appearing in the *Loire Médicale* Dr. Blanc calls attention to a cause of dystocia hitherto unmentioned in treatises on midwifery. The cause resides in the abnormal softness of the foetal head from arrest of ossification. The practitioner is called to a case where the normal conformation of the pelvis and the equally normal development of the foetus promise, with the coöperation of good and regular pains, a speedy delivery; but the head makes no progress, uterine inertia supervenes and instrumental aid is necessary to effect delivery. In these cases the incompletely ossified head can be felt by the exploring finger to present an abnormal softness of the bones, parchment crepitation being yielded on pressure, the fontanelles are unusually large and the sutures are abnormally wide. The practitioner has to deal with a soft head (*tête molle*). Irregularity of descent, flexion, &c., are the result, and the resistance of the perineal floor is not overcome as by a head possessing the usual firmness. As soon as the diagnosis is made recourse must be had to the forceps.—Correspondence of *Lancet*.

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BALTIMORE, MAY 13, 1893.

## Editorial.

### PUERPERAL SAPRÆMIA AND SEPTICÆMIA. PUERPERAL INFECTION.

This ever interesting subject was up for consideration again at the recent meeting of the State Medical Faculty, having been appointed for special discussion upon that occasion.

The treatment of the theme by the referees, Drs. J. E. Michael, J. Whitridge Williams and T. A. Ashby, and by the co-referees, Drs. Wilmer Brinton, W. S. Gardner and L. E. Neale, was most admirable, as was attested by the close attention given to the speakers by the large audience present.

As puerperal sepsis is one of the most important conditions with which the practitioner has to do; having intimate relations with the whole field of parturition and touching the health and life of every mother in the land; it is pleasant to observe the strain of scientific conser-

vatism which marked the discussion before the Faculty. The sentiments expressed by the participators, who excellently represent the obstetricians of Maryland, justify us in the belief that the future graduates of our Baltimore schools will continue to be trained in the most advanced principles of midwifery.

The degree of immunity from sepsis reported from our lying-in hospitals is extremely creditable to the physicians and nurses in charge.

### THE STATE BOARD OF MEDICAL EXAMINERS.

The wisdom of our legislators in decreeing this Board, and the wisdom of the State Medical Faculty manifested in its choice of examiners, were both abundantly shown in the report presented by the Board to the Faculty on the last day of its recent annual meeting.

In spite of defects in the law, some of which were perhaps unavoidable, it is evident that persons hereafter beginning the practice of medicine in our State will either have to prove their fitness for the responsibilities of medical life, or else will find their path a very thorny one.

If we understand the temper of the present Board it means war to the death against all law-breakers. There is plenty of "clean grit" in the constitution of the Board; and, furthermore, the profession of the State, if we know it, is proud of the Board's energy and pluck and will back it up in its efforts to do its duty.

All quacks and impostors will please note that Maryland has lost its pristine charms as a "happy hunting-ground" for their ilk, and will kindly turn aside to



States which are still in the darkness of medical chaos.

As the mouth-piece of the profession of Maryland, we voice its appreciation of the services rendered by the Board individually and collectively during its brief existence.

Especially is the prudence of the Board commendable, in that it has dealt leniently with the candidates who have appeared before it in this its first year. It is only fair that the difficulty which our colleges find in suddenly raising their standards, especially in the non-medical preliminary courses, should be taken into consideration in judging the attainments of their graduates.

The Board will make its hold on the public and the profession all the more secure by making reasonable allowance, as it has done, for shortcomings for which the student is little, if at all responsible.

### Medical Progress.

#### PLACENTA PRÆVIA.

In the treatment of placenta prævia the first requisite to success is good judgment on the part of the attendant, as at different stages and under different conditions he has to choose different methods. To summarize the modern treatment of placenta prævia, as practised by our latest authorities, I would formulate the following rules:

1. Hæmorrhages before the seventh month are likely not to be due to placenta prævia, and call for delay, to allow, if possible, the child to reach a viable age. Such cases must be closely watched.

2. After the seventh month, if a single copious or repeated slight hæmor-

rhages can be positively diagnostic as due to a placenta prævia, induce premature labor.

3. A single slight hæmorrhage, if due to placenta prævia, calls for absolute rest, preferably in bed under the constant care of a trained nurse.

4. All cases of profuse hæmorrhage require the tampon or hydrostatic dilators to check hæmorrhage until the os is dilated sufficiently to allow the introduction of two or more fingers into the womb, or until bleeding ceases from the pressure of the child.

5. When the indications point to the induction of labor, Barnes's dilators should be used, the placenta having been previously separated and the edge reached on one side if possible; if the pains are then good and the head presenting, the case may be left to nature, otherwise version should be performed and a leg brought down to plug the uterine outlet.

6. When labor occurs spontaneously the Barnes dilator or tampon may be required to check hæmorrhage, the indications then being the same as in the last case.

7. In shoulder-presentations, when the child is movable in the uterus, cephalic version may be performed by the external or combined method, and the case then left to nature, or the forceps may be applied.

8. In other cases of transverse presentation, after separating the placenta on one side and dilating the os, podalic version is indicated.

9. In cases in which podalic version is indicated it should be performed at the earliest possible time, one leg only being brought down and the case then left to nature.



10. Extra care should be taken with these cases to guard against post-partum hæmorrhage, and strict measures employed to prevent septic infection.—*Med. News.*

#### A FORM OF RECTAL SINUS.

In the *Memphis Medical Monthly*, May, Dr. Coop writes: I desire to call attention to an affection which I do not think is very generally understood. It is an affection denominated *pilo-nidal sinus*, a Latin term, which, being translated literally, is hair-nest sinus. I have never seen any mention of such an affection in any literature whatever; yet, I have witnessed two such cases myself—one in Moses Gunn's Clinic at Chicago, and one case that occurred in my private practice a year or so ago.

This sinus is situated an inch or so above the tip of the coccyx behind, and in the internatal groove, or crease; and there are one or more dimples, or sulci, near where this sinus makes its appearance—a dipping down of the skin into the tissues beneath, as it were. The subjects of this difficulty are very hairy individuals, and may be of either sex.

The apparent origin and cause of this affection is brought about in the very early foetal formation. There is too much folding in of the dermal tissues, or skin elements, in the early foetal formations, burying, as it were, the hair follicles, where they lie dormant, awaiting that period called puberty, or perhaps the age of adolescense, when these imprisoned and latent hair follicles are stimulated into activity. They then produce a growth of hair in the form of a bundle, or wisp; and from its buried presence in the tissues beneath, and being constantly irritated from external

sources, it finally causes suppuration, and the pus is discharged through an opening made by ulcerative absorption. Then, following this, there may be a periodical, or continual, discharge, until the hair, and finally parts containing the hair follicles, are destroyed or dissected out by a surgical procedure. This trouble may be said to be caused from a condition in early foetal formation—just the reverse of that condition known as spina bifida. This last-mentioned malformation is caused by not enough joining together of the external blastodermic membrane, and the cause of this hair sinus is too much joining of said blastodermic membrane. Consequently, the affection named in the caption of this paper must have its origin and cause in the imperfect joining of the internal blastodermic membrane, which, according to physiologists, produces the malformation known as harelip and extrophy of the bladder, and some other deformities.

#### NITRO-GLYCERINE.

In certain conditions the action of nitro-glycerine or glonoin is marvelous. When a powerful stimulant is indicated, its universality of action distinguishes it from all others; and if given more freely than is necessary for the exertion of its influence in this way, it not only operates on the brain especially, but does so with great energy. In favor of nitro-glycerine is its smallness of bulk; and as an antispasmodic and nervous stimulant it has no peer amongst medicines of that class. In a case of emergency, one drop of a one per cent. solution may be placed on the tongue or inside the upper lip when the patient is in an unconscious condition. Its effects are immediately ob-

served, by its property of relieving spasm; which it certainly does to a remarkable degree. Its effects are immediately manifested by the capillaries carrying more blood than they had done before its administration; the radial pulsation grows fuller, freer and more rapid; and there appears an increased warmth of the extremities. An overdose of it produces giddiness, weakened vision, headache, with throbbing in the temples, a sense of weariness, sleepiness, and severe pain in the cardiac region, with unusual trembling. Since the introduction of nitroglycerine in therapeutics, I have not had an opportunity of testing its virtues in puerperal eclampsia; although my observations of its *modus operandi* as a nervous stimulant and a remedy in some other affections, especially those of a spasmodic character, have been quite satisfactory. —*Times & Register*.

#### EMBOLISM FOLLOWING DIPHTHERIA.

Rooney (*Occidental Medical Times*, vol. vii, No. 4, p. 188) has reported the case of a girl of seven, living amid favorable hygienic conditions, who developed diphtheria three days after the death of a brother of eleven from the same disease, after an illness of five days. The illness was a severe one and attended with albuminuria, but on the twelfth day a tardy convalescence set in. Three days later, without premonition, the child uttered a gasping, smothered cry and appeared about to die. It clasped the precordium with both hands; gasped for breath, while the surface of the body was blanched and cold and covered with a profuse perspiration. Relief followed in a short time, but the child continued to complain of pain in the region of the umbilicus and of coldness and numbness

of both legs. By the use of hot blankets and stimulants warmth and feeling were restored to the right leg and to the left to the level of the knee, below which point the limb was cold, bloodless, and shrunken. The action of the heart was rapid and regular, but weak. The temperature was slightly below the normal. There was complaint of intense pain in the toes of the left foot, and the leg was flexed upon the thigh and could not be extended on account of pain. A diagnosis of embolism of the left popliteal artery was made, and it was decided to await the formation of a line of demarcation. A bed-sore formed; the child greatly emaciated; and it was finally determined that amputation must be performed without delay. It was feared that death would take place in the course of the operation, but the outcome was successful, recovery being ultimately perfect. On examination of the amputated member an embolus an inch and a quarter long was found lodged in the popliteal artery at its bifurcation into the anterior and posterior tibials.—*Medical News*.

#### CENTRAL BIRTH PALSY.

In the *British Medical Journal*, April 8th, Dr. Oliver discusses this class of lesions and gives three illustrative cases.

In the first, that of R. H., a boy 14 years of age, there was deformity of left foot and arm, and some affection of speech, following a forceps delivery and convulsions.

In the second case there was precipitate labor, meningeal hæmorrhage, death. The labor was, comparatively speaking, easy. It was, perhaps, rather precipitate, and therefore the compression would be sudden, for the whole period of



labor scarcely lasted an hour and a half. The baby was born with very severe pains before the arrival of the doctor. The child was extremely feeble from the time of its birth. It was a head presentation, and the child had in no way been injured after its escape from the vulva. From the first the child's respiration was extremely feeble, and the beat of its heart weak. The child was so prostrate and lifeless that it could scarcely swallow a few drops of liquid. It died on the third day from what appeared to be sheer exhaustion. At the post-mortem examination several hæmorrhages were found under the skin of the occipital region, under the dura mater, over the vertex of brain, and under the tentorium cerebelli. Other portions of the membrane of the cerebellum were extremely hyperæmic; the brain and cerebellum were healthy, and there was no effusion into either of the lateral ventricles. In addition there were numerous small hæmorrhages varying in size from a pin's head to a pea. The vessels in the pia mater were distended; some had ampullar dilatations upon them, whilst others could be traced into the effusions of blood. Both lungs were engorged, were firm to the touch, and were studded here and there with reddish-black dots of pulmonary apoplexy. These conditions, not unlike those of the early stages of pneumonia, are to be explained by atelectasis due to insufficient respiratory force. The other organs of the body were healthy.

In comment, Dr. Oliver says: Here, then, was a case where meningeal hæmorrhage occurred during parturition without the forceps having been employed, and apparently where no long-continued compressing influences had

been at work; and if the child had lived, in addition to mal-developments, there would undoubtedly have been the characteristic symptoms of birth palsy.

It is hæmorrhages, such as the one I have described, spread over the vertex and posterior part of the brain that have been found by Gowers and others in cases where convulsions, rigidity, and paralysis were present either at birth or shortly after it. Meningeal hæmorrhage occurring under these circumstances upon the vertex either compresses the convolutions of the brain, or it tears the cerebral tissue, or the blood is poured out at the base in the posterior fossa, and surrounds the medulla and cerebellum. Basal hæmorrhage is regarded by McNutt as that most likely to arise when there has been a head presentation, whilst the effusion of blood upon the vertex, on the other hand, is regarded as more likely to develop when it has been a foot presentation. Without accepting this as absolutely true, it is no doubt what would be most likely to happen. In a breech presentation, for example, where all but the head is born, the neck of the child is caught more or less by the muscular ring at the exit of the uterus and the base of the skull being also more or less compressed, there would be impeded escape of blood from the brain, and the vessels at the vertex, thereby inordinately distended, might easily rupture, and the result would be an extravasation of blood upon the surface of the brain. Necropsies made upon infants that have died shortly after birth have demonstrated the existence of this form of meningeal hæmorrhage, and in the case of children that have survived this disaster and died



years afterwards, having exhibited during life the characteristic symptoms of birth palsy, post-mortem examination has shown the lesion to have been one of atrophy of the convolutions of the motor area. The appearances presented could only be explained by the supposition of there having been a hæmorrhage which had inflicted injury upon the brain, the blood having been slowly absorbed, leaving, however, considerable damage done to the cortex. The seat of the hæmorrhage, generally upon the vertex, explains the symptoms, namely, paresis of the muscles of the legs and arms. The effusion may extend lower down upon the ascending frontal convolution, and destroy the centres for the muscles of the face whilst the excessive knee-jerks and rigidity in all cases would be due to descending degeneration of motor tracts, and the spontaneous movements to the persistence of damaged nerve cells in the cortex. In R. H. the disease is unilateral but in many it is bilateral, and where this is the case the paralysis is more marked on one side of the body than the other, the two limbs most affected being always on the same side.

#### OBJECTIONS TO THE NASAL SPRAY.

All astringents, whether vegetable or mineral, sprayed into the anterior nares act as irritants, the degree of irritation depending upon the strength and temperature of the solution, the condition of the mucous membrane and the idiosyncrasy of the patient, but always acting as irritants in a greater or less degree. The alkaline sprays are perhaps less irritating; still I think it may be safely said that the spraying of any cold, watery solution into the anterior nares

is injurious. I mean injurious, of course, in a limited sense, and do not wish to be understood as saying their use is followed by any very grave or marked symptoms, for experience has taught us that the nasal mucous membrane is an exceedingly hardy structure, that it endures the vicissitudes of climate, the vices of civilization, as well as the blunders of medical science, if not uncomplainingly at least with a degree of toleration that shows it to be endowed with remarkable powers of resistance. The use of sprays in cases of acute coryza prolongs and intensifies the attack. In chronic rhinitis they complicate matters by engrafting upon it an acute attack. They always make the patient exceedingly uncomfortable during and for some hours after treatment. The substitution of vaseline and other petroleum products as a menstruum has done much to mitigate the evils of the aqueous solutions. First, because they are of themselves non-irritating; secondly, because they decrease or nullify the action of the drugs applied to the mucous membrane; but their use is open to serious objections aside from that they are therapeutically inert. They arrest or at least greatly impair the respiratory functions of the nose by forming an impervious coating to its entire mucous surface; they prevent the giving off of heat; they prevent the exhalation of moisture; they prevent the exchange of gases that should normally take place in the nasal cavities. In short, this protecting of the nasal mucous membrane with vaseline, of which we have heard so much, simply means that we abolish the respiratory functions as long or often as we apply protection, so that the inspired air, in-

stead of reaching the larynx and lungs saturated with moisture and raised to a temperature approximating that of the blood, is cold and dry as in buccal respiration. It is admitted even by their most zealous advocates that their prolonged use produces a condition very closely resembling atrophic rhinitis.—*Amer. Prac. and News.*

#### ARTHRODESIS.

Roersch, of Liege, has recently called attention to a special application of resection of the knee, to which very little attention has been paid in this country and which, even when the recognized indications for this operation were more numerous than at the present day, was seldom noticed in text-books on surgery. In most of these works it will be found that the list of such indications deals exclusively with instances either of some morbid condition limited to the joint, or of crippling of the limb from previous articular injury or disease. Of late the tendency with most surgeons has been to diminish the range of resection, especially with regard to the knee, and to very few must the idea have occurred that the removal of this joint whilst in a sound condition might prove indirectly beneficial for the relief of the results of non-articular disease. We are reminded, however, that in 1878 Albert, of Vienna, resected both knees, which were structurally normal, of a girl affected with essential paralysis of the lower limbs, with the object of establishing ankylosis and of converting the atrophied and yielding members into two firm columns of support. To articular resection performed with this aim the title of arthrodesis has been given. Albert's example has been followed by Von Winwarter and several German surgeons, and

his innovating orthopædic method has recently met with firm supporters in France. Roersch, in his review of the history of arthrodesis, omits to mention that the method has been tried in this country also, and practised in cases of paralysis of the lower limbs by Mr. Wright, of Manchester, and by Mr. Jacobson, of Guy's Hospital.

Whilst Albert and most of his followers would regard arthrodesis as the suppression of a healthy joint with the object of rendering a paralyzed limb firm and solid, Roersch would apply this term to the establishing of ankylosis in a diseased as well as in a sound joint. A resection of any weak and loose joint would thus be regarded as an instance of arthrodesis, and the method thus called would have included in its list of indications arthritis deformans and tabetic and other neuropathetic affections of joints. Roersch would extend the list still further, and regard secondary resection for failure of ankylosis after removal of a diseased joint as a measure of arthrodesis. He would add also resection of the extremity of the bone in cases of congenital and other forms of luxation in which reduction cannot be maintained. Still further indications are found in old and aggravated club-foot and in paralytic talipes. This extended application of the term cannot fail to cause much confusion, and it would be better to restrict it to its original meaning, so as to imply by its use the operative suppression of a very loose but otherwise healthy joint in cases of infantile and other forms of persistent muscular paralysis.

The knee, although it presents the most favorable conditions for the estab-

lishing of osseous ankylosis, is not the only joint on which arthrodesis has been performed. Both the ankle and the hip-joints have been resected in cases of paralytic affections of the lower extremity, the former perhaps more frequently than any other joint, the latter but seldom. In the upper limb indications for arthrodesis do not often occur.

With regard to the results of this heroic treatment, which must necessarily be practised on those who would seem to be unfavorable subjects for any kind of surgical intervention, a most striking fact is the freedom of the operations from any serious risk. Of the ten cases treated by Von Winiwarter, which are reported in Roersch's paper, not one had an immediate fatal result, and no mention of such misfortune is to be found in any of the numerous cases that have been recorded by other surgeons. Such results are remarkable as *opérations de complaisance*, of which arthrodesis may be taken as a good example, are, as is generally believed, peculiarly subject to risk. We need, however, definite information as to the later results of this treatment, and the amount of benefit to be derived from it. Jacobson and Wright have obtained good results, but hitherto, we believe, few cases have been recorded in this country. In France, arthrodesis has found several warm supporters, and Roersch, one of the most zealous of these, asserts that it has been attended with success. The results obtained by Von Winiwarter in most of his cases of infantile paralysis seem to have been very favorable, several patients being able after resection of two or more joints to move about without crutches or any artificial supports to the paralyzed

limbs. Death occurred after long intervals in two cases, in one from injury, in the other from diphtheria, but there is no record of any failure. Peterson, who excised the knees in two cases of infantile paralysis, states that his patients were delighted with the results. On the other hand, Wolff is disposed to commiserate the subjects of these multiple operations, and to regard their future lot as being far from enviable.—From an editorial in the *British Medical Journal*.

#### TUBERCULOCIDIN.

Klebs has sent out a pamphlet in which he gives the results obtained by him in the treatment of tuberculosis by his new remedy, tuberculocidin. This substance is obtained by precipitating Koch's tuberculin by platinum chloride, removing the noxious elements, and leaving the albumose in solution. This albumose contains the curative principle of tuberculin. Of it, a dose equal to  $\frac{1}{5000}$  of the body weight may cause only half a degree (C.) rise of temperature in a tuberculous guinea-pig. Tuberculocidin exists in tuberculin in the proportion of 1 to 40; so that the dose of the former is  $\frac{1}{40}$  that of the latter. It is regarded by Klebs as a secretion of the tubercle bacilli. In favorable cases it causes decomposition of the bacilli, which, after the injections, are found in the sputum presenting a granular appearance, as in the old cavities; irregular in size and shape, imperfectly stained and presenting evidences of decomposition. These changes disappear when the injections are discontinued after a few days' trial, and reappear when the tuberculocidin is again employed. The temperature may rise sharply after the



first injections, but a decided antipyresis follows, and the daily range soon approaches the normal. Large doses may cause so much malaise and emaciation that they must be discontinued; to be resumed if the temperature again rises. Tissue changes observed, such as exudation into tubercular tissues, are due to the natural tendency of the bodily tissues to repair, when the tubercle bacilli have become weakened.

As to the results, Klebs has studied seventy-five cases, mostly of pulmonary tuberculosis, long enough to warrant deductions from their course. Of these, fourteen cases were cured, forty-five improved, fourteen unimproved, and two died. Of his own cases, eight were cured, twenty-one improved, two unimproved and two died. Among the unimproved were a number of very advanced cases.

Local tuberculosis was not included in this list. Laryngeal phthisis was notably benefited, and necrosis of the tissues and spread of the bacilli never occur during treatment with tuberculocidin. Unless there is fever or hæmorrhage, the patient can attend to business or to the ordinary occupation. If the fever persistently recur and the debility be great, Klebs advises the additional treatment by the rest-cure, benzosol, suralimentation, and a residence at Davos.

In the use of tuberculocidin he recommends the Overlach syringe, carefully cleansed before using, by absolute alcohol and then by carbolic solution, one per cent. After using, the carbolic solution is again applied, and then the alcohol. The initial dose is two to five milligrams. If the fever remains below 38° C., the dose may be rapidly in-

creased to six or eight centigrams; the curative dose for man being ten to fifteen centigrams in all, or at least five cubic centimeters of the undiluted lymph. A rise in temperature is an indication for an increase in the dose.—*Times and Register*.

#### ACUTE TORSION OF SPERMATIC CORD.

Since I first reported in this journal of June 6th, 1891, a case of strangulation of the epididymis due to torsion of the spermatic cord, operated on at the South Devon Hospital, Plymouth, by Mr. Whipple, there have been three cases reported—one by Mr. Bryant, in a paper read at the Royal Medical and Chirurgical Society on Feb. 23rd, 1892; the second by Mr. Davies Colley in the *British Medical Journal* of April 16th, 1892; and the third by Mr. Herbert Page in the *Lancet* of July 30th, 1892. I have now to record a fifth case, which in onset of symptoms resembles the others but in treatment differs, as it was relieved without operation.

On March 17th, 1893, a school boy, aged 19, in perfect health, at 3 P. M. jumped a form, from 3 P. M. till 5.30 P. M. was boxing at intervals, at 6 P. M. had tea, and at 6.30 began to feel seedy. At 6.45 P. M. he went to bed, and then first felt a pain in his right testicle. At 7.30 P. M. he vomited, and at 7.45 I saw him. He was then pale and faint, and complained of pain in his right testicle, extending along the spermatic cord.

The testicle and epididymis was very tender and somewhat swollen, especially the latter. On tracing up the swollen cord from the epididymis, about one inch above the top of the testis I found a very tender lump about the size of a

cobnut. Above this the cord was not altered in any way. The external abdominal ring was not unduly patent. The epididymis lay in front of the body of the testis; there was no urethral discharge. The fact that the epididymis was in front of the body of the testis, that the testis and epididymis were swollen and tender, that there was a distinct lump or knot involving the cord, above which the cord was normal, and below which there was swelling, made me believe that the cord was twisted. I therefore decided to attempt to untwist it. I rotated the epididymis in front of the testis to the patient's left, but it caused more pain and would not stay in that position. I next rotated it to the patient's right, so that it resumed its normal position behind the body of the testis. It remained so, and the lad at once said that all pain had gone. In two minutes the swelling of the testis and epididymis had gone, and in half an hour nothing remained of the trouble except some hardness and swelling of the cord at the point of twisting. All faintness and pallor had passed off. Next morning there was no trace of anything unusual.

*Remarks.*—In all the five cases mentioned the patients were young, their ages being 14, 15, 16, 17 and 19. In my two cases the immediate cause appears to have been a strain, but in the other three no cause is mentioned. In the first three cases the testicle was imperfectly descended, and in Mr. Page's case there was an inguinal hernia. In the present case the testicle was in its proper place, and there was no undue patency of the external abdominal ring. In all of the cases the symptoms were

much the same, namely, the appearance of a painful swelling in the groin and vomiting. In the first four cases the nature of the swelling was only discovered on performing an exploratory operation. In all the cases the epididymis had been more swollen than the testis, and in my first case the testis, to the naked eye, appeared normal. I have no doubt that, if the nature of the present case had not been recognized, the testis and epididymis would have continued to swell and necessitated an operation.—Dr. Nash, in *British Medical Journal*, April 8.

#### ABDOMINAL CORSET AND SALOL FOR DIARRHOEA.

In the *Virginia Medical Monthly* (May), Dr. Brodnax writes:

Perhaps the following may be new to some, as I have, in my time, met several "graduates" who had never heard of the mode of treatment; but, on my recommendation, tried it and found it a perfect success.

Doctors will often run on a case of a child, from one to three or four years old, sallow or pale, a constant desire (three or four times a day) to have an action from the bowels. The action does not smell as it should, is thin, and perhaps greenish. The child is impassive or fretful, seems to be sluggish and peevish. On examining the abdomen, it will be found more or less protruded or swollen—"paunch bellied"—which condition has often lasted for months.

Such cases are very rebellious to treatment with or by medicine. But by a very simple arrangement, a sometimes magical effect is produced in a very few hours. This is my plan, and from experience I can cordially recommend it;

Make a broad band of, say, cotton flannel, double or lined with flannel, large enough to go nearly around the abdomen and wide enough to reach from the pubes to the breast bone; have the band so short that it will not meet by three inches in the back. Now sew on some tapes about an inch apart on each end and opposite one another, and you have what might be termed a many-tailed bandage. Put this on the child pretty tight, and every night and morning tighten it a little. Give some, say, three or four half-grain doses of calomel, and then give turpentine tea in teaspoon doses every hour or two, with half to one grain of salol.

My idea is that the intestines are distended by fermentative gases, and cannot force out their contents or absorb the nutrient juices of food necessary to sustain life. By compressing the abdomen, the intestines regain their normal contractility, and, by emptying themselves, cure is set up; and the peevish, fretful infant, relieved of the constant neuralgia of the bowels, becomes happy and healthy.

I have used this appliance, which I call an "abdominal corset," for over twenty-five years. My grandmother had used it on her plantation sixty years before she told me of the plan. So it is really very old practice (minus the salol).

#### PERIPHERAL BIRTH PALSY.

Writing at length upon this theme in the *British Medical Journal*, April 8, Dr. Gay, of London, says:

#### DIAGNOSIS.

The diagnosis is not always so easy as might at first appear. A case may not come under observation until the early history is forgotten, and as at any rate

one instance is recorded in which several members of a family were successively affected, the absence of such history might lead to the belief that they were suffering from a hereditary form of amyotrophy. In the cerebral variety of birth palsy it is extremely uncommon for a single limb to be implicated, and difficulty can only arise when the arm is the affected, for, as far as I know, no case has yet been recorded of peripheral birth palsy of the leg. The paralysis of cerebral origin is at one time or another associated with a certain amount of spasm, giving rise to a true contracture, which contrasts with this simple flexion or extension of the joints occurring in peripheral paralysis. Duchenne has recorded a very interesting case, and one very difficult to explain, in which there was spasm of some of the muscles of the arm associated with atrophy of the interossei and thenar muscles. There is no defect of sensation in cerebral cases, but convulsive seizure of the Jacksonian type may possibly occur. Peripheral birth palsy is not likely to be mistaken for cerebral syphilis or infantile paralysis, since the latter occur only during the later periods of infancy. Parrot's or pseudo-paralysis may occasion some difficulty, though only rarely, for its most frequent date of onset is from the second week to the second month. Porak, Parrot and Guénoit have, however, described cases existing from birth, and as in two of these the paralysis was associated with certain fractures, the likeness to peripheral birth palsy was very close indeed. The points of distinction are these. Pseudo-paralysis is, as the name implies, no paralysis at all, and if the limb be carefully watched movements of some of the distal joints



may generally be observed; although, too, none of the cardinal signs of syphilis are at first present they soon develop, and there is periostitis, separation of epiphyses, or some evidence of syphilis of the long bones. The course of the disease is at first progressive, and its termination is either towards rather rapid recovery under treatment or death. In peripheral birth palsy, on the other hand, the paralysis is at first complete, there are not necessarily any signs of syphilis, and the condition is chronic. Besides, the muscles do not respond normally to the faradic current, and the paralysis is limited to one arm and possibly the face of the same side.

#### PROGNOSIS.

Ross considers the prognosis unfavorable, but Gowers asserts that most obstetrical cases recover slowly. The records of such cases as I have been able to consult would seem to show that complete recovery is rare, but that no improvement at all should take place is perhaps equally rare. The rule is that some movements eventually become possible, but, compared with those of the healthy limb, are weak and ill-sustained; for example, a child whose arm hung pendulous by its side at birth may after a time be able to raise the hand to his mouth. That such cases, which have possibly been under treatment for some months, should completely recover when lost sight of appears very improbable. The retention of faradic contractility, though diminished, shows that the rupture or laceration of the nerve trunks is not complete, and is therefore a favorable prognostic sign.

#### TREATMENT.

Electricity is the only method as yet

suggested for the treatment of these cases. This, to be successful, must be commenced at an early stage of the disease, and carried out in a systematic manner. Henoeh truly observes that "the persistent employment of electricity can be of service only so long as the nerves have not undergone fatty degeneration and the muscles still react," that is, to faradism. There are chiefly two indications in carrying out the electrical treatment: (a) to play upon the affected nerve roots, and (b) to preserve as far as possible the nutrition of the muscles. The former is best obtained by placing a comparatively large electrode over the supra-clavicular fossa, where the roots of the brachial plexus lie, and another in the armpit. The current to be employed in this area is either the faradic or interrupted voltaic of moderate strength, and the application should be continued for five minutes or more. Each of the affected nerve trunks may be treated in a similar, though less thorough manner. The second indication is fulfilled by subjecting the paralyzed muscles to a galvanic or galvano-faradic current with both poles successively for about five minutes. This treatment should be continued for several weeks.

#### INFLAMMATION.

The *Medical Record* reviews as follows the modern view of inflammation:

There has been going on among pathologists a decided revolution in their views of the nature of the inflammatory processes, and it is quite time for the thoughtful physician to wake up to the fact of this change. In a recent series of masterly lectures on the subject, Metchnikoff has presented the results of a long and laborious study of inflamma-

tion as it occurs in all forms of animal life. (Vegetables, he says, do not have inflammation.) Metchnikoff goes much further in presenting his theory than most pathologists, but in many of his fundamental ideas there is nothing at variance with accepted facts. Underlying all forms of inflammation is the general law that the process represents a reaction of the organism to irritants. The irritants capable of causing inflammation were formerly thought to be almost any foreign substances; later it has been believed that only microbes and microbic products can cause inflammation, and for the surgeon this is still practically true. It has been shown, however, that certain chemical and mechanical agents can cause inflammatory changes. Much stress has always been laid upon the blood vessels and connective tissue as being the tissues primarily and essentially involved.

It is from this view that Metchnikoff most positively dissents. For him, inflammation is a matter of cells. These cells all come from the mesoderm and are lymphoid in character. Without a mesoderm there would be no inflammation. The irritant particles in the body have the power of drawing these lymphoid cells to them, and this power is called chemotaxis. Having reached the irritant body, be it a microbe or toxine, the cell proceeds to devour it and render it harmless. The cell is therefore called a phagocyte, and inflammation is "phagocytic reaction of the organism to an irritant." Metchnikoff finds four kinds of leucocytes in the body. Only two of them, the mononuclear and polynuclear, have much phagocytic power. They originate in the lymphatic glands, the

spleen, bone, marrow, and blood. The polynuclear leucocytes have chiefly the latter origin. The different leucocytes are differently affected by different irritants, and in accordance with the chemotaxis and the kind of phagocyte we have different kinds of inflammation. Tubercle is one type; syphiloma another; suppurative and exudative inflammations furnish still other examples. The part played by nervous and vascular tissues in inflammation is necessarily secondary to the phagocytic process.

One fact that follows from the new view of inflammation is that this process cannot be idiopathic; it cannot arise without some poison or infection. Again, an inflammation has a tendency to subside. It cannot be kept up unless the infection or poison is a continuous one. Chronic nephritis and chronic hepatitis are, therefore, misnomers, unless it can be shown that a chronic irritant exists. Already, therefore, pathologists show a tendency to place some of the chronic inflammations in the category of degenerations.—*Medical Record*.

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### Medical Items.

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Dr. A. K. Bond has removed his offices and residence to 889 Park Ave., between Biddle and Howard Sts.

Fatty tissue, liable to pressure or irritation, should always be removed in surgical procedures, as its necrosis frequently causes persistent fistulæ.

Tetanus in a child was treated by Celli with nine hypodermic injections, each containing five centigrams of cor-

rosive sublimate. At the end of a week the child was well.—*Kansas Medical Journal*.

Chloride of ethel should be very cautiously used in producing local anæsthesia about the face, for should it be inhaled it is liable to produce alarming symptoms, such as lividity and difficult breathing. Over-freezing with it, too, will produce a dermatitis.—*Ex.*

From recent reprints received, in which the subject of surgical treatment of cancer of the rectum is discussed by two men, eminent in rectal surgery, it appears that while colotomy is the permissible procedure in the vast majority of cases, excision is the ideal operation when the cancer is within easy access through the sphincter, *i. e.*, not more than three inches above, and has not extensively infiltrated the adjacent tissues. *Kansas Medical Journal*.

Antipyrin, acetanilid and similar compounds should be given very cautiously for the relief of pain in persons about to be exposed to cold; not that they reduce normal bodily temperature, for it has been shown that they do not, but because of their influence are capable of decreasing the production of animal heat by rendering the vaso-motor system less active in adjusting itself to the circumstances with which it is surrounded.—*Ex.*

Drs. Parish and A. M. Phelps, of New York, during the past year have made operations for tendon anastomosis in cases of infantile paralysis with success. In Dr. Parish's case the tendon of the paralyzed extensor pollicis was joined to the tendon of the healthy anterior tibial muscle. In Dr. Phelps' case

the tendon of the paralyzed gastrocnemius and soleus was joined to the healthy long flexor of the toes. The junction was made with cat-gut sutures and the wounds closed without drainage. In both cases a marked gain was made in the use of limb.—*Ex.*

The appointment of Dr. James A. Steuart, our former City Health Commissioner, to succeed Dr. Chancellor as Secretary of the State Board of Health, is received by the profession with mingled feelings of pleasure and regret. Of pleasure, arising from personal friendship for Dr. Steuart and the conviction that his long service to the State as Health Officer of Baltimore has given him not only a claim upon the gratitude of its citizens, but also unusual experience in public sanitation. Of regret, because the duties of the secretaryship seem at this time to require the services of a young man who will be more ready to seek the advice and aid of other physicians and hygienists.

The following programme has been arranged for the eleventh annual meeting of the American Medical Editors' Association, at Milwaukee, June 5. The business meeting will be held at 4 P. M. The President, Dr. Culbertson, will deliver an address. Dr. Gould will read a paper on "Medical Orthography." This will be followed by a paper on "Some New Phases of Journalism," and a discussion. Reports of committees and election of officers and other business will conclude the session. The banquet will be given at 6.30 P. M., and be followed at 8.30 by the annual address by Dr. Ernest Hart, editor of the *British Medical Journal*. This will be followed by an address on "Editorial Responsi-



bility and Questions of Libel," by the Hon. Clark Bell, editor of the Medico-Legal Journal, and president of the International Medico-Legal Congress. Dr. J. Stanly Hall, editor of the Psychological Journal and president of Clark University, will address the Association on "Psychological Phases of Medical Study and Journalism." Discussion and remarks will follow.

Secretary, T. D. Crothers, M. D., of Hartford, Conn.

We learn through the daily press that Dr. J. Rufus Tryon has been appointed Surgeon-General of the Navy.

Dr. Tryon was appointed to the navy September 22, 1863, from New York, as assistant surgeon, and has served successively in the grades of passed assistant surgeon, surgeon and medical inspector. In receiving this promotion as surgeon-general he skips the grade of medical director, of which there are fourteen on the active list.

The appointment is somewhat in the nature of a surprise.

It is said that the selection of Dr. Tryon establishes a new policy in the navy, in so far as this administration is concerned. It indicates that no officer will be appointed to bureau positions who cannot serve out his full term before reaching the age of retirement.

Surgeon-General Tryon was born in New York. He served in the West Gulf squadron from 1863 to 1865; in the Naval Hospital at Boston 1865 to 1866. He was with the Asiatic squadron from 1870 to 1873, and was on special duty in connection with the yellow fever epidemic at Pensacola, Fla., from 1873 to 1876, since which time he has been on

duty at New York and Philadelphia. He was attached to the Alaska on the Pacific station, 1882 to 1883, and in 1884 was a delegate to the International Medical Congress at Copenhagen. He was then on the European station until 1887, and was afterwards on duty at New York until October 1891, when he was ordered to duty on the United States steamer Chicago, and has remained on that duty up to the present.

As the new medical school of the Johns Hopkins foundation will demand elaborately constructed buildings, which, if we may judge from the time taken to build the hospital, will require much time for their construction, it has been uncertain how the trustees could meet the requirements of Miss Garrett, that the school should be opened in the autumn of the present year. The public is now informed that two additional stories will be built over the pathological laboratory, one of which stories will temporarily accommodate the medical school.

Incredible as it may appear, a number of our physicians seem to be still ignorant concerning the location and management of the Directory for Nurses.

The Directory is located still at the northwest corner of Saratoga and St. Paul Sts., in the hall of the State Faculty. Its office is open daily except Sunday, from 12 to 6 o'clock; telephone 1825. At other hours nurses may be obtained by application to the Registrar, Dr. C. Hampson Jones, 25 W. Saratoga Street, next door to the Rennert Hotel. A cash fee is required before securing the sick-nurse.

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### Original Articles.

#### IS BALTIMORE SUPPLIED WITH GOOD DRINKING WATER?\*

BY CHARLES O'DONOVAN, M. D.

Baltimore City is supplied with drinking water from two sources—Lake Roland and Loch Raven — formed by damming two streams which drain contiguous watersheds. Into Lake Roland, which is situated about five miles north of Baltimore, on the Northern Central Railroad, and is made by a dam across Jones' Falls, flow three principal streams, one each from the west, north and east, each draining a fertile section of populous and thickly settled country; into each, after a heavy rain, is washed the earth of many ploughed fields and

the accumulated filth of many barnyards, and, worst of all, the refuse of many sinks and privies. The western stream is probably purest and best, coming down through Green Spring Valley, but it is contaminated by the washings from Rockland and a few villages along its course; the stream from the north is quite small, but its course is just under Lutherville and Ruxton, of which growing villages it forms the natural sewer; the stream from the east is by far the worst, as upon its course lies Towson, the county seat, built on both sides of the steep ravine through which it flows. This is the worst feature of our water supply; every heavy rain that visits Towson washes the accumulated filth of about two thousand people and several hundred horses directly down a steep incline into this stream, which carries

\*Read before the Medical and Chirurgical Faculty, April 27, 1893.

its poisonous burden to Lake Roland, about a mile and a half away, whence we draw our drinking water. In the summer time it often happens that for weeks at a time no water passes over the crest of the dam at Lake Roland, and the only purifying influences that the water experiences is sedimentation. It requires no great amount of reasoning to see that water drawn from an agricultural district, richly cultivated and scientifically fertilized, must present a good culture medium for the lower forms of microscopic life; especially must this be the case when such water is gathered into a large stagnant pool and there exposed to the full glare of our summer sun. If such a medium became infected with the germ of typhoid fever or of cholera, nothing short of a miracle could save those hapless beings who must drink it. That such infection should occur it needs only that one case, flying from quarantine, should seek an asylum somewhere on the populous banks of the streams mentioned, or among the numerous summer boarding houses that line the shores of Lake Roland itself. Nowhere is there a more inviting field. We all know the custom of the country: dejecta are thrown at once either upon the ground, into the most convenient stream of water, or used as manure upon some garden patch on the banks of the streams; let a thunderstorm arise at about the same time and down into the turbid lake goes the poisonous filth, to be drawn from our hydrants as pure country water by the thirsting inhabitants of the city. Towson is a thriving town, it increases every month in population and extent; it is a remarkably unhealthy town, it is noted for the prevalence of typhoid fever within its limits its; drinking water is

drawn entirely from wells and springs. Again and again have its inhabitants been urged to provide themselves with pure water, but in vain; yet the central open sewer that receives all that rain can wash from this entire community, flows directly into Lake Roland, and thence is distributed for drinking water in Baltimore. There is no filtration of any kind, and the only purification is that obtained by sedimentation when the water stands stagnant either in Lake Roland or some of the distributing reservoirs. From this it appears that the water drawn from Lake Roland is so bad that it cannot be used for drinking purposes without great danger.

Loch Raven is ideally situated on the Gunpowder River, about nine miles from Baltimore, and extends for about five miles in a deep gorge, shaded on either side by high cliffs that are covered with excellent timber; to one who visits the spot no finer basin could be imagined to contain the pure drinking water of a healthy town; all about the scenery is wild and picturesque, and for miles along the shores no sign of human habitation can be seen. Let us follow up the streams from the dam and see if their sources are equally free from the possibility of pollution. The Gunpowder River traces its entire course through a fine, rolling country, well watered by numerous streams, fed by a multitude of springs; the entire watershed is populous, being entirely an agricultural region of great capability, which is well farmed in the most approved manner, well ploughed and abundantly fertilized with barn-yard manure and chemical fertilizers. There are but six villages of any size in the entire watershed.

As one advances along Loch Raven



the first considerable stream on the left flows through an agricultural region entirely; it drains all that country lying between the York Pike and the river from Towson as far north as Timonium; the water should be as pure and sweet as spring water can be, as it receives no filth except what washes with heavy rains from fields and from about country houses. The same may be said of the stream that comes down Dulaney's Valley from the north and empties into Loch Raven nearly opposite to the mouth of the stream mentioned above. On either of these, or on any of the streams that I shall call pure, minor nuisances may exist, such as too close proximity of a house or outbuildings; but for all practical purposes, they are as pure as any country stream may be expected to be. Advancing up the river, the drainage on either side is by small streams from sparsely settled farming or grazing country, and along high hills on either side intersected by deep gorges; well wooded, with a fertile meadow here and there, until we reach the Warren factory, about two miles above the head of Loch Raven. I consider this factory town of about five hundred inhabitants a standing menace to the health of Baltimore. The mill is built directly on the bank of the river, about six feet above its bed; it is very cleanly in its surroundings and carefully guarded against the spread of any nuisance. But the town is very different; it lies for the greatest part along the course of a turbulent little stream that tumbles down a steep incline between two high hills, with just space enough for a road that follows its course and the houses that line the road on both sides. There are

other houses in the village scattered about, but it is to these that overhang the water-course that I would direct attention. Whatever filth or nuisance of any sort that may have accumulated about these houses is washed with every rainstorm directly into the stream, and so into Loch Raven about two miles below; cattle, pigs or poultry have access to this stream and help to contaminate its water, already too foul for drinking purposes; and it empties into the Gunpowder River just at the head of the still water that is formed for a half mile below by a dam that runs a small grist mill; below that dam there is a stretch of about a mile and a half over boulders and amongst rocks before the head of Loch Raven is reached. The bottom of all this river is of mud or stones covered with mud, the soil that is washed from the cultivated fields all about, and higher up the river. Any system of inspection that endeavors to keep pure our water supply should watch Warren most carefully.

A short distance above Warren the Gunpowder receives the water of the "Western Run," which drains the rich region stretching from Texas for several miles north along both sides of the York turnpike, and including Cockeysville and Ashland, small villages of about one or two hundred inhabitants. The sanitary condition of this watershed may be considered satisfactory, except at two points; Texas, which is closely built and far from clean and discharges directly into one of the smaller branches of Western Run, and the distillery at Cockeysville, which has been the source of a great deal of bother to the various health officers of Baltimore. With these

two points carefully guarded, especially Texas, the water from the Western Run may be accepted as being as satisfactory as may be expected from a highly cultivated farming region. About a mile and a half beyond the mouth of Western Run is Phœnix, a village of about two hundred people formed by the factory hands of the Phœnix mill. Here is an exact repetition of what exists at Warren; the mill is on the river bank, operated in great part by water power flowing from the turbines back at once into the Gunpowder River, the mill and immediate surroundings are scrupulously clean, but the village follows for a quarter of a mile along the course of a little torrent coming down the steep hillside, which forms a perfect open sewer into which flows all that water can wash from about the houses and yards. This stream empties into the mill-race just below the mill, about fifty yards from where the race empties again into the river. Phœnix is a town that is notably unhealthy; typhoid fever is a frequent disease there; it is directly on the line of the Northern Central R. R., an admirable resting place for refugees fleeing from a cholera scare or outbreak, whence incalculable harm to the health of Baltimore might result; it forms one of our most vulnerable points. Above Phœnix the country becomes more open; the river flows no longer through hilly defiles, but through a pleasant rolling country given to excellent farms throughout. At Glencoe, a small village about three miles above Phœnix, the houses cluster about a small stream, but are not so close nor so numerous as at the larger factory towns. Above Glencoe are no special sources of contamination,

unless it may arise from some barnyard too near, or other outhouses discharging directly into one of the numerous streams that flow into the river. The water is always turbid after a heavy rain and great quantities of earth and sediment of various kinds come down stream with each freshet, to be deposited later by sedimentation in one of the mill ponds or in Loch Raven. This latter is rapidly filling up by such action, but with that we need not deal at present.

From this brief outline we may reach readily the following conclusions:

1st. That the water of Lake Roland is unfit for drinking and should be used only after thorough filtration or boiling.

2d. That the supply from the Gunpowder River is at present good, and would be excellent, if the nuisances could be abated that exist at present at Texas, Phœnix and Warren.

3d. That most rigid watch should be kept at these and other points of possible danger to provide against the contamination of the Gunpowder River.

I might add also that it would be an excellent thing for the city of Baltimore to purchase land in the Gunpowder watershed, especially about the sources of streams and along watercourses, and retire that land from cultivation, allowing trees to grow and encouraging their growth by planting and protection. Such land is now purchasable at very low figures, and available tracts are in the market at frequent intervals. Especially should all the present forests be maintained. It is a well-known fact that streams rapidly fail when the country along their banks is denuded of timber growth. Such has been the result along the Gunpowder within my



own recollection, and it should cease at once. If the present watershed that pours its water into Loch Raven were protected, and if the springs that supply it flowed from beneath hills covered with timber, we in Baltimore need fear no water famine for a century, but if the present course be pursued, if timber be cut constantly from the hills, if mills be allowed to locate along the streams, and no proper supervision be given to the system, it must follow that in a few years, just as Lake Roland has become unfit for use so will the Gunpowder supply fail us. There are many hillsides above the dam that are useless for farming that could be purchased for a trifle and made to yield a regular supply of water, if planted with trees, instead of washing in gullies with every storm and loading the streams with mud and soil. Each day brings the danger nearer; with the extension of rapid transit the population of outlying districts must increase, and when it is too late, when Loch Raven shall have become like Lake Roland, then perhaps we shall bewail our lost opportunity.

3 E. Read Street.

### THE REPORT OF A CASE OF FRACTURE OF THE THYROID CARTILAGE.\*

BY WILLIAM J. TAYLOR, M. D.,

Surgeon to St. Agnes' Hospital; Assistant Surgeon to the Orthopaedic Hospital and Infirmary for Nervous Diseases, Philadelphia.

C. E., carpenter, aged forty-three, was admitted to the surgical ward of St. Agnes' Hospital on October 6, 1892, in a semi-conscious condition. He was unable to give an account of the accident,

but a fellow-workman reported that he had fallen a distance of about twenty feet, from a scaffold upon which he had been working. No one saw him fall but when he was discovered he was unconscious and lying across a heavy piece of wood. When admitted into the hospital a short time afterward, he was unconscious, could be roused from his stupor, but could give no account of himself. He was very much shocked. The right side of his face was badly contused, the right eye was swollen and completely closed. He was bleeding from the nose, mouth, and left ear, and his general appearance was that of a man suffering from a fracture of the base of the skull. The pupils were equal, and a very careful examination shows this diagnosis to be an error. He had great difficulty in breathing, could not swallow, the saliva ran out of the corners of his mouth, and when he attempted to speak, his voice was husky and his articulation very indistinct; he could not speak above a whisper, and only that with the greatest pain and difficulty. There was little or no swelling of the neck, but when he regained complete consciousness he complained of great pain and discomfort in the throat.

A careful examination now revealed a fracture of the thyroid cartilage on the right side, extending from above downward about on a line with the insertion of the thyro-hyoid muscle and about two lines anterior to it. The amount of displacement was very slight, but the mobility of the fragments could be easily demonstrated, and the fragments displaced and replaced again by manipulation with the fingers.

Dr. Smock, the laryngologist to the

\*Read before the Philadelphia Academy of Surgery, March 6, 1893.



hospital, very kindly examined him very shortly after his admission, and confirmed the diagnosis of fracture of the thyroid cartilage. He reported also a rupture of the tympanic membrane about at the extremity of the manubrium process of the malleus. The nose showed hæmorrhagic points on the septum on both sides.

Dyspnœa was pronounced, but there was apparently no emphysema about the seat of the fracture or in the neck. His symptoms were severe, and the pain and discomfort very great, but I did not think them sufficiently so to demand immediate relief.

Dr. White, the resident surgeon, was instructed to make all preparations for instant tracheotomy, and to send for me if the symptoms should increase in severity. He was to use his own judgment, however, and to operate at once without waiting for me to arrive should the necessity arise. No attempt whatever was made to apply a dressing. For some days the bleeding from the mouth persisted, and the difficulty in swallowing and dyspnœa continued, but gradually lessened, and by the end of three weeks was entirely gone. His voice still remained somewhat husky, but there was no longer pain or difficulty in swallowing. The left ear was treated by cleaning out the auditory canal with cotton, and insufflating daily aristol and boric acid.

Dr. Cyrus Edson has been appointed Health Commissioner of New York City.

The Pennsylvania Legislature has passed an act establishing a medical examining board like our own.

### Society Reports.

#### THE CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MARCH 17, 1893.

The 278th regular meeting was called to order by the President, Dr. William E. Moseley.

Doctors Charles F. Nolen and Arthur H. Mann were elected to membership.

*Dr. J. Whitridge Williams* read a paper on

#### THE TREATMENT OF POSTERIOR DISPLACEMENTS OF THE UTERUS.

(See page 1.)

After outlining the various modes of treatment and giving more in detail Duhrssen's method for vaginal fixation, Dr. Williams summed up his own ideas as to the proper course to be pursued in the treatment of these cases as follows:

In all cases in which the uterus is movable, it should be replaced by bimanual manipulation and a suitable pessary introduced.

In cases in which the uterus is adherent, we should attempt to free it from its adhesions by massage and the use of vaginal applications, and failing in them, we should resort to Schultze's method of loosening the adhesions under an anæsthetic.

If by these means we are able to free the uterus from its adhesions, it should be replaced and a suitable pessary introduced. If necessary the vagina and perineum should be repaired by a plastic operation.

It is only in cases where the pessary treatment is of no avail or in cases in which the uterus cannot be freed from its adhesions that there should be any

thought of resorting to operative treatment and then only when the retroflexion give rise to symptoms of considerable gravity.

The practice of operating at once upon a case of retroflexion without any attempt at more conservative treatment can not be reprehended too strongly.

The operative treatment of retroflexions uncomplicated by tubal or ovarian disease should differ as the uterus is movable or markedly adherent.

If the uterus be movable we do not consider ventral fixation a justifiable operation, and would most emphatically recommend some form of vaginal fixation; preferably Dührssen's method. We have tried this method ourselves, and from our limited experience are inclined to believe that it will accomplish all that Dührssen claims for it.

If, on the other hand, we have not succeeded in freeing the uterus from its adhesions, and the symptoms are sufficiently grave to justify a capital operation, there can be no doubt as to the propriety of performing cœliotomy and stitching the uterus to the abdominal walls by one or other of the methods mentioned.

We do not wish to be understood as being opposed to ventral fixation, for we are not; but we are opposed to indiscriminate and reckless operating upon this class of cases.

The consideration of the treatment of retroflexions occurring as complications of serious tubal or ovarian diseases resolves itself into the treatment of the primary affections.

*Dr. B. B. Browne* spoke of two classes of cases which it was extremely difficult to treat by the use of pessaries; those

in which the uterus joins the vagina without any projection of the cervix into the vagina and those in which there is a retro-lateral version. In regard to the ventral fixation of the uterus, he thought that in a good many cases it is a very desirable operation, especially in those cases where the tubes and ovaries are diseased and have to be removed. In cases of retroversion accompanied by tubal or ovarian disease he always fixes the uterus at the time he removes the tubes and ovaries. In a great many cases of retroversion, dilatation and thorough curetting and the use of the pessary for a month or two will work a permanent cure. Many of these cases are simply cases of chronic subinvolution and curetting and tamponing will reduce the size of the uterus and it will remain in place without a pessary after two or three months support.

*Dr. Wm. E. Moseley* said he had the pleasure of seeing *Dr. Williams* operate in two cases by Dührssen's method of vaginal fixation and the result in one case which he examined afterwards was most gratifying. This operation is not known in this country. It certainly seems to be a very reasonable one and will in many cases take the place of ventral fixation or other intra-abdominal operations for displacements.

*Dr. Hiram Woods* read a paper on  
DISEASES OF THE MASTOID REGION,  
WITH ANALYSIS OF 41 CASES.

All the cases showed more or less external evidence of disease, most of them presenting the symptoms of pain, swelling over the mastoid region, fluctuation and prominence of the auricle. With reference to the association of mastoid disease with lesions in other parts of the

ear, these 41 cases divided themselves as follows: Occurring with disease in the middle ear, 35; occurring with otitis externa, 5; of uncertain nature, and possibly primary mastoiditis, 1.

Of the 35 cases associated with middle ear disease, 12 developed in acute, 20 in chronic suppurative otitis media, 3 in acute aural catarrh without perforation of the drum membrane. All of these cases demanded surgical interference, but three would not consent. One of these, a girl of 17, had a bulging Schrapnell's membrane, without perforation, and fluctuating mastoid swelling. She recovered slowly under mercurial treatment. She had, the writer thought, that form of mastoid disease called by Sexton "dissecting tympano-mastoid abscess." The other patient was a baby with chronic otorrhœa. It died of meningitis. The third unoperated case was one of necrosis. Upon 32 Wilde's incision was done with such further surgical procedure as this operation showed to be necessary. Two of these cases had acute aural catarrh without perforation. Pus was found external to mastoid cortex, but no opening could be discovered in cortex. Both recovered promptly. These cases the writer classed as tympano-mastoid abscesses. Of the remaining 30, in 20 a carious spot was found in the cortex, in different situations, leading to an abscess cavity, in 6, more or less extensive necrosis was discovered; in 4, pus was found outside the cortex, and the latter was unaffected. The opening of the abscess cavity and the drainage thus established removed all mastoid symptoms in these 20 patients. In 17, the pre-existing otorrhœa is known to have ceased. This point was not recorded

in the other three. Of the cases with necrosis, two recovered as soon as the sequestrum was removed; two of the others had a slight otorrhœa persist. A fifth had too much necrosis to allow of complete removal, and would not consent to thorough operation.

Of the four with no pus external to the cortex and intact cortices, 1 was chiselled and made an excellent recovery; 2 obtained relief from Wilde's incision and left the hospital. The fourth upon whom it was intended to do the chiselling operation had a discharge into the tissues of the neck and recovered in this way.

The five cases associated with otitis externa presented the classical symptoms of mastoid disease, but there was neither history nor symptom of middle ear disease. Otitis externa was present.

The forty-first case, classed as a possible primary case, was a child of 2½ years old. There was no history of ear disease, but there was a large mastoid abscess. The rest of the ear looked healthy, save one point in the drum-head which may have been a healed perforation.

Dr. Woods reviewed the constitutional treatment of mastoid otitis, and expressed the opinion that reliance should not be placed upon it for any considerable time. Wilde's incision was better antiphlogistically and therapeutically. He thought, too, that the relief afforded by this operation; the occurrence of mastoid symptoms in connection with other ear disease than inflammation of the external ear; the possibility of there being another course for the spread of inflammation from the tympanic cavity to the mastoid, other than through the antrum and cells, made



the early and thorough opening of the mastoid cells, of late years so strenuously urged by some authors, an operation of doubtful utility.

*Dr. Randolph* thought that the Wilde method was a faulty one and that a larger incision, under proper antiseptic precautions, did not increase the gravity of the operation, while it exposed the bone sufficiently to enable one to discover just what portion of it was involved. He had noticed frequent relapses after the Wilde incision.

*Dr. Harlan* said that there were only very meagre statistics on the subject to be had, but from those which he could find and from his own observation and that of his acquaintances, it seemed that mastoiditis is rarely a fatal disease. Nature takes care of these cases in a wonderful way. An otorrhœa is an objectionable thing but the number of people having it and still living out their years independently of it is very great. The inspissated masses which occur in neglected otorrhœas have been shown to contain very large quantities of streptococci, and in operating one is likely to infect the wound that he makes by setting free these germs. If an operation is done at all it should be done very thoroughly. A case in point was a healthy vigorous man of forty, who was treated for polypus in the ear. A large polypus was removed and a number of smaller ones were being scraped away. After this operation the man had a fainting spell at his place of business. *Dr. Harlan* was called to him the next day and on the next day following the man became completely unconscious, and had heavy, sterterous breathing. No tenderness over the mastoids.

He operated, gouging clear into the antrum, where he found a teaspoonful of pus. The man died six hours afterwards.

As to Wilde's incision, it is hard to understand why it does so much good. As an illustration of its efficacy, *Dr. Harlan* mentioned a case in his practice of a young girl of three and a half years who was brought to him, having a profuse otorrhœa with red and swollen ear. The child had not slept for two nights. Under chloroform, *Dr. Harlan* made a free incision after the manner of Wilde. No pus was found. The child went to sleep shortly after the operation and the next day was bright and at play. By the following day the discharge had almost entirely ceased and within four days had absolutely ceased.

*Dr. Bernstein* thought that if antiphlogistic measures were more thoroughly tried in cases of mastoid disease that the necessity for operation would be far less frequent.

*Dr. Harry Friedenwald* said that a great many cases of mastoid inflammation get well without surgical procedure, either of their own accord or by more or less vigorous antiphlogistic treatment. As to Wilde's incision, he did not think it was proper surgery to make a small incision and then wait for results. If it is necessary to cut down over the mastoid it is certainly necessary to try and find out, if possible, the cause of the swelling or pain.

An incision of at least two inches in length should be made and the periosteum thoroughly pushed back. There is greater danger in these mastoid troubles than many surgeons believe. There is no anatomical reason why a mastoid abscess

should always open externally. These abscesses are just as near to the brain as to the external surface. Dr. Friedenwald did not believe that the mastoid operation was dangerous when proper precautions were employed. Drills should never be used and chiselling should never go beyond the depth of  $\frac{1}{2}$  an inch. He has never regretted having operated early. He lost one case by late operation and another case died because brought in too late for operation.

Dr. Woods thought that inasmuch as many cases get well after Wilde's incision, there is no necessity, in the absence of any particularly dangerous symptoms, to do the radical mastoid operation at first. He believed after Wilde's incision was made a thorough search should be made over the mastoid until the source of the trouble was found. Dr. Woods asked Dr. Friedenwald if he would have chiselled in to the mastoid in the case of the little girl described by Dr. Harlan. He replied that he would. Dr. Woods did not think the operation would have been justified.

W. T. WATSON, M. D., Sec'y.

1519 N. Broadway.

#### PNEUMONIA.

In closing an article upon this subject, Dr. Cannon (*Kansas Medical Journal*, May) writes: I desire to call attention to some observations extending over several years, viz.: In croupous pneumonia of the left lung, in either lobe, the expectoration contains much more blood, amounting almost to hæmorrhage at times; that left side pneumonias depress the heart more than the right side consolidation, and are much more fatal; that apex consolidation on either side is accompanied with more delirium than

when it occurs in the lower lobes; that I have never seen a typical case of prune-juice sputa as described in the text-books and would be much alarmed if I did see it. Walshe, in *Diseases of Lungs*, says all cases of pneumonia with hæmorrhage he considers tuberculous. Dobel disputes it, and I agree with Dobel, for I have observed many cases after the excessive blood-spitting spoken of above make good recoveries with no symptoms of tuberculosis developed as yet.

#### IS LUNACY REALLY INCREASING?

The Blue-book recently issued by the General Board of Lunacy for Scotland refers to the marked increase of pauper lunacy all over the country, and ascribes cause to; 1st. The widening of medical and public opinion, as to the degree of mental unsoundness which may be certified to be lunacy, and as such to require care and control. Thus, cases of epilepsy, senility and mild imbecility, which formerly would not have been classed as insane, are now often put on lunatic roll; 2nd. growing unwillingness to keep insane relations at home, due greatly to the public not tolerating peculiarities of conduct, which make an insane person more or less repugnant to his neighbors; 3rd. institutional care is more appreciated, and therefore more frequently resorted to, than formerly. It is not unfairly resorted to, however, as scrutiny of admission lists shows.—Dr. Norbury, *Jour. Nerv. & Ment. Dis.*

Powdered starch, found in every kitchen, is very cooling to an irritated skin.

Surgeon General Wyman reports that the quarantine service on our coasts is uniformly good.



## MARYLAND MEDICAL JOURNAL.

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BALTIMORE, MAY 20, 1893.

**Editorial.**MEDICAL AND CHIRURGICAL  
FACULTY OF MARYLAND.

The following are the officers for the coming year:

President, George H. Rohe; Vice-presidents, John D. Blake and John S. Fulton; Recording Secretary, G. Lane Taneyhill; Assistant Recording Secretary, Robert T. Wilson; Corresponding Secretary, James M. Craighill; Reporting Secretary, William B. Canfield; Treasurer, William F. A. Kemp.

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Examining Board for Western Shore: P. C. Williams, J. E. Michael, David Streett, William E. Moseley, B. B. Browne, James McShane and Herbert Harlan.

Examining Board for Eastern Shore: W. F. Hines, B. W. Goldsborough,

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Memoirs: E. F. Cordell, E. P. Irons, S. A. Keene, J. L. McComas and G. T. Atkinson.

Ethics: I. E. Atkinson, H. M. Wilson, E. G. Waters, C. G. W. MacGill and J. McPherson Scott.

Program: Wm. H. Welch, T. A. Ashby, Charles W. Mitchell, Harry Friedenwald and J. W. Humrichouse.

Curator: Wm. T. Howard, Jr.

The following special committees were appointed:

Permanent Location: Louis McLane Tiffany, B. B. Browne, H. P. C. Wilson, J. J. Chisolm, G. Lane Taneyhill, Wm. H. Welch, Robert W. Johnson, Wilmer Brinton, Thomas A. Ashby, I. Edmondson Atkinson, Philip C. Williams, George H. Rohe, Aaron Friedenwald, George J. Preston and Henry M. Thomas.

Moral Reforms in City: P. C. Williams, Aaron Friedenwald and A. K. Bond.

Membership: T. A. Ashby, H. Woods, Jr., T. D. Kennedy, B. W. Goldsborough and W. Q. Skilling.

The following delegates were appointed to attend various State medical associations.

In Virginia: William Lee, William B. Canfield, Thomas H. Brayshaw, William T. Howard, Jr., Frank M. Chisolm, I. R. Page, Robert L. Randolph and Robert T. Wilson.



In West Virginia: B. Merrill Hopkinson, W. P. Chunn and George A. Fleming.

In North Carolina: J. J. Chisolm, Randolph Winslow, A. K. Bond and L. E. Neale.

In New Jersey: B. D. Evans, J. Percy Wade.

The delegates to the American Medical Association to be held in Milwaukee, Wis., commencing June 6th, are: G. T. Atkinson, Edward Anderson, B. R. Benson, C. Birnie, J. B. Brawner, Robert Bond, J. J. Chisolm, James M. Craig-hill, D. W. Cathell, J. E. M. Chamberlain, S. Chase DeKraft, G. E. Dickinson, J. W. Downey, F. E. Fooks, Aaron Friedenwald, R. F. Gundry, John C. Harris, J. W. Humrichouse, J. D. Iglehart, C. Hampson Jones, W. F. A. Kemp, J. L. McComas, J. L. McCormick, W. E. Magruder, W. H. Marsh, A. H. Price, George H. Riggs, Monmonier Rowe, J. A. Stevens, David Streett, W. A. B. Sellman, L. Gibson Smart, E. A. Scott, G. Lane Taneyhill, J. Whitridge-Williams, Robert T. Wilson, Thos. H. Williams, E. M. Wise, J. E. Benson, W. H. Campbell, Thos. L. Craig, Fredk. Dunning, F. Elgin, B. D. Evans, John S. Fulton, B. W. Goldsborough, W. B. Gambrill, J. H. Lamar and Wm. Lee.

#### SANITATION IN BELAIR.

Being a native of Harford County, Md. the editor is of course fully convinced that that county is one of the garden spots of the world. However this may be, no one who has ever visited its county-seat will doubt that Belair has one of the finest hygienic locations in Maryland. It is situated on a high plateau of considerable fertility, far from

all marshes and other sources of miasmatic influence.

Yet Belair, like most of our smaller towns, is exposed to the most imminent danger from contamination of its water-supply through imperfect sewerage.

Drawing its drinking water from local wells, which are closely adjacent to the time-honored privy-well or cess-pool and in many cases receive more or less of the yard-slops, the town is liable at any time to epidemics of dysentery and enteric fever, or of the less distinct and unnamed digestive disorders.

It is therefore with considerable interest that we note in the columns of the daily press that, under the benign stimulus of the cholera scare, the citizens of Belair, and prominent among them, of course, her physicians, have set on foot a movement for the improvement of her sanitary conditions.

On May 14th a meeting called by the town commissioners was held in the court-house to consider the subject. Dr. J. C. Butler was elected chairman. Dr. Wakeland Munnikhuysen dwelt upon the need of a good system of sewerage, and urged citizens to guard against decaying vegetable matter and foul cess-pools. Dr. C. A. Hollingsworth said he thought that the continual cleansing of cess-pools by a stream of running water was very important. Other citizens, not physicians, advocated the substitution of dry-earth closets for cess-pools.

The meeting then adjourned for two weeks in order to permit the town commissioners to confer with the State board of health.

We congratulate Belair upon its activity in the matter, and will be glad to learn of the future progress of the movement.

**Medical Progress.****FOR BALDNESS.**

In the *American Practitioner and News*, April 22, Dr. Shoemaker gives an extensive review of alopecia and its treatment, from which we take the following extracts:

For a patient with indigestion he ordered hoang nan. This remedy is of double utility. It stimulates secretion of the digestive fluids, and it has a special influence upon the sebaceous glands. It may be combined as follows:

R<sub>y</sub>.—Extracti hoang nan fluidi, f. 5iss.

Extracti chiratæ, fluidi, f. 3ss.

Acidi hydrochlorici diluti, f. 3ijss.

Aquæ menthæ piperitæ, q. s. ad.  
f. 3ij.

M. Sig: Teaspoonful in water three times a day.

In cases which are associated with anæmia we should administer preparations of iron, manganese, arsenic, or chlorate of potassium. Sulphur is another excellent constitutional remedy. It is a normal constituent of hair and essential to its nutrition. Sulphur is beneficial in seborrhea sicca when given in five grain doses thrice daily and for a considerable period.

One of the best methods of stimulating the glands and follicles of the scalp is by the application of galvanism and faradism. The interrupted current should, in the beginning, not exceed three or four milliamperes, applied by means of moistened sponge electrodes. I am much in the habit of using faradism passed through a brush with metal bristles, the moistened sponge electrode being held by the patient.

Circumscribed alopecia requires treat-

ment adapted to the constitutional condition of the patient and the cause of the affection. General and local galvanism is an excellent method of treatment. As the patient before us has not fully recovered his strength after an exhausting disease, I shall put him upon the following mixture:

R<sub>y</sub>.—Acidi phosphorici diluti, f. 3ijj.

Tincture ferri chloridi, f. 3ijj.

Syrupi simplici, q. s. ad. f. 3iv.

M. Sig: Teaspoonful in water thrice daily.

As a local application in this case we shall make use of the ointment of the mercurious oleate. When the patches are pale active stimulation is usually necessary. Ointments containing naphthol, thymol, sulphur, iodide of sulphur, cantharides, chrysarobin, turpentine, tannic acid, or veratrine are efficacious. Shaving the patches has frequently a beneficial effect, and singeing the hairs when they begin to be reproduced is also of utility. Sometimes it is necessary to use a blistering fluid, such as the tincture of cantharides, one-half dram to the ounce of alcohol. Small but rebellious patches may be painted once a week or ten days with cantharidal. Large spots do not allow such heroic measures.

**CONTAGIOUSNESS OF LEPROSY IN INDIA.**

The Indian Commissioners have arrived at the conclusion that, though leprosy must be classed amongst the contagious diseases, yet the risk of contagion is so small that it may practically be disregarded, and the attention of the reformer or legislator should, therefore, be directed towards the removal of pre-

disposing factors. They base their conclusion on the following reasons:

1. With one questionable exception, all the instances of a possible contagion which they personally met with have broken down.

2. In no case could contagion, or the possibility of it, be demonstrated free from objection.

3. The disease does not spread sufficiently amongst members of a family.

4. Leprosy very seldom spreads from husband to wife, or *vice versa*.

5. There is no risk of a diffusion of leprosy by means of vaccination.

6. Leper communities in India have never acted as centres around and from which leprosy has been diffused amongst the population. Segregation or partial isolation cannot explain this, as in places like Amritsar the lepers are not restricted in any way.

7. The belief that people who go bare-foot are liable to be inoculated through wounds on their feet is unfounded, for the cases shown in evidence of this assumption were very doubtful and problematic; bacilli were never found in the dust removed from leper huts, though doubtful bacilli were obtained on examining earth from the footwalks of the Almora Asylum.

8. All the persons who had lived many years in close contact with lepers, either as their attendants or being retained in asylums on the suspicion of being lepers, and who were seen and examined by the commissioners, have remained untainted, with one, or perhaps two, exceptions.

#### PREDISPOSING CAUSES OF LEPROSY.

There seems to be some connection, accidental or otherwise, between the

dampness of climate and the prevalence of leprosy, and it appears that in those areas where cholera is, endemic leprosy is especially prevalent. No causal connection between the two diseases is suspected, but areas where cholera is endemic must present certain permanent conditions which may lead to a predisposition to leprosy.

There is also some evidence that leprosy is most prevalent in the most poverty-stricken areas. Altogether the commissioners attach great value to poor and insanitary conditions, bad social surroundings, and so forth, as factors of importance in the etiology of the disease.

The native population is most prone to the disease, and the unmixed European least. This difference depends probably on the inequality of social rather than racial conditions.—*Ex.*

#### CHOLERA PRECAUTIONS.

From a long list of wise recommendations given in the *Therapeutic Gazette* we glean the following:

Keep your presence of mind in the danger; avoid too great anxiety, for it clouds your clear judgment. Only the man who thinks clearly can make proper use of the precautions against danger.

Maintain cleanliness of your person and surroundings. Discretion, temperance, precise cleanliness, prove the best protection against disease.

Hold firmly to your ordinary regular mode of life. Avoid festivities and assemblages of people.

Do not leave your home in order to escape the disease. Consider that you may be in greater danger in traveling, and living under altered conditions in a



strange place, than while leading a careful, regulated life at home.

To make boiled water taste well, add to each glass (half a pint) as much tartaric acid as you can take on a knife-point, or two drops of hydrochloric acid.

Eat and drink nothing which is in a sick-room. Consider that flies and such insects might carry the germs of disease from the patient to your food.

Excretions of persons ill with, or suspected of having cholera, and the floor, etc., soiled with them, disinfect by copious (at least hourly) use of slack lime or chlorinated lime solution (5 drachms chlorinated lime to 1 quart cold water), or other trusted disinfectants.

If your digestion is disturbed, if you have diarrhoea, especially with vomiting or great nausea, consult a physician at once.

Until he comes, take a warm drink, put on a woollen bandage about your body, remain in your room; if in great distress, go to bed.

For relief, you may take a cup of tea, with cognac or rum. Let your food be a mucilaginous soup, also zwieback, or stale white bread without butter.

If you have reliable (prepared from a physician's prescription) cholera drops at hand, take a dose.

Keep your presence of mind, even if you are ill. Fright and cowardice act unfavorably on body and mind.

#### EPILEPTIC COLONY.

The State Charities Aid Association of New York secured at the last session of Legislature the passage of an act providing for the appointment of a Commission for the selection of a site and plan for an Epileptic Colony in that State.

The Commission, consisting of Messrs. Craig, Letchworth and Walrath, of the State Board of Charities, made their report to the Legislature early this month, recommending the purchase of a fine tract of land, about 1,800 acres, situated in the Genesee Valley, Livingston County, and now owned by the Sonyea Society of Christian Believers, with buildings thereon.

This property is admirably adapted for the objects in view, as is fully shown by the Report of the Commission. The land is extremely fertile, there is a fine water supply, the climate is healthy, and the buildings, which include a church or chapel, schoolhouse, a structure suitable for a hospital, a laundry, dining hall, and numerous cottages for dwellings and shops, besides extensive barns and stables, are just what will be needed in the colony.

These 1,800 acres and the buildings upon them can be purchased for the moderate sum of \$125,000, and can be made ready for occupancy at but little additional cost.

The bill asks for an appropriation of \$150,000 for the above purposes.

The colony is to be controlled by a board of nine managers appointed by the Governor and confirmed by the Senate.

The establishment of such a colony will be an incalculable blessing to the five or six hundred dependent epileptics now scattered through the poorhouses and almshouses of the State, and to a very large number of poor and indigent epileptics outside the poorhouses, offering them a chance of education and employment in trades and industries and in agricultural life. It is intended to make

the colony self-supporting so far as practicable.

From an economical point of view a great opportunity is offered the State, and from a humane point of view, a still greater.

In the colony, epileptics will receive special and scientific care, and let us hope that at some future time a cure for this dreaded disease may possibly be found, as one beneficent outcome of the establishment of this colony.

The bill, which has been drafted by a special committee of the State Charities Aid Association, is appended.—*Jour. Nerv. & Ment. Dis.*, April.

#### A PHYSIOLOGICAL EFFECT OF CAVE VISITING.

Dr. Hovey's interesting account of a visit to the Mammoth Cave in March, published in *Science* for April 7, 1893, recalled a recent conversation with my father, Dr. C. Fayette Taylor, on the subject of the cave, which he visited in July, 1860. He was particularly struck with, and vividly describes, the physiological effects experienced on emerging from the cave. He made the usual trip with some fifteen companions, reaching upper air after a stay of about twelve hours under ground. On emerging, the sense of smell was intensified to such an extraordinary degree that most common objects, such as trees, plants, animals, and even people, had strong individual odors, mostly unpleasant; about half the party were strongly nauseated and vomited. One tree could easily be distinguished from another by its characteristic odor. This effect lasted about half an hour and then passed off. The guides told him that this was a usual ex-

perience. Dr. Hovey alludes to this effect of a sojourn in the cave in a lecture published in the Bulletin of the American Geographical Society, March 31st, 1891, in the following words: "By contrast with the pure oxygenated air of the cave, the odors of the outside world, of the trees, grass, weeds and flowers, are strangely intensified and for many delicate natures overpowering." In a letter dated April 11th, 1893, Dr. Hovey says: "I have always, or generally, been accustomed to rest at the entrance on emerging, for the reason that neglecting this precaution is apt to be followed by disagreeable consequences. I have known visitors to suffer from nausea and headaches by reason of a too sudden change from the peculiarly pure air of the cave to that of the outside world. The sense of smell is greatly intensified in almost every case."—*Science*.

#### ACUTE RENAL DISLOCATION.

The attacks usually supervene upon some violent exertion, and each attack seems to render the individual more liable to another. Usually without any warning the patient is seized with a violent pain in one or other of his kidneys, which might radiate down the thigh. These attacks of pain simulate the paroxysms of renal colic, but may be distinguished from them by the non-passage of a stone, and by the tenderness and intestinal distension over the region of the affected kidney, which usually supervenes after an hour or two. Sometimes the kidney itself is felt to be distended if an examination is made during the progress of the attack, but the distension is never excessive, because it is only in the early stages of a hydronephrotic



tumor that such attacks usually occur. Later on, when the kidney has been more distended, and when its movements are not so limited in character, less pain is experienced by stoppage of the ureter. To such a train of symptoms the term dislocation seems to be very appropriate, for in some instances actual reduction takes place either with or without an anæsthetic, and if this occurs the pain ceases quite suddenly.—Dr. Clarke, *Ex.*

#### SWEETBREAD.

Several correspondents have written to point out, in connection with the proposal to treat diabetes by the ingestion of fresh pancreas, that it is not sufficient to recommend a patient to obtain a "sweetbread." The true sweetbread, regarded by *gourmets* as a great delicacy, is the thymus gland of the calf. As a rule, this is found only in the fœtus and young calf, under the lower surface of the trachea, "partly without and partly within the chest, between the layers of the anterior mediastinum." It is occasionally persistent, but usually disappears within a few months after birth. It is elongated, of a greyish-white color, irregular—that is, lobulated on its surface, and much more resembling a salivary gland and the pancreas than the thyroid. It is commonly known amongst butchers as the "throatbread," and rarely found except in animals supplying young veal or lamb. The pancreas is vulgarly termed the "gutbread" or "belly sweetbread," and is the article which would be supplied in the great majority of cases by butchers asked for sweetbread. The thyroid is situated at the upper part of the neck, not at its root, and is not regarded as a favorite article of diet. Though the lobes are closer together than in man,

they are spoken of as two, each being named a "kernel" or "gland." As far as we can learn, they are not ordinarily included among the sweetbreads. As compared with the thymus and pancreas the thyroid is very small, regular on the surface, ovoid in shape, reddish-brown in color, situated at the upper part and not at the root of the neck. The thyroid is sometimes confused by butchers with the lymphatic glands of the neck. Its dark color and characteristic shape—convex externally while somewhat concave and flattened where it rests against the trachea—should prevent this mistake. While thymus and pancreas are valued highly, the market value of the thyroid is inconsiderable, and until its association with myxœdema it was rarely asked for.—*Ex.*

#### THOUGHTS ON PNEUMONIA.

In the *British Medical Journal*, April 13, Dr. Goodhart, of Guy's Hospital, presents a very interesting paper on this disease in which he says: Both sides were affected much more frequently in children than in adults. Very often, if the chest were auscultated carefully, although the main disease was situated, say in the scapular region on the one side, there would be heard some evidence, more or less pronounced, of disease on the other, and usually somewhere about the root of the lung. Some earlier affection of the bronchial glands might be the determining cause of this double affection. This frequent incidence of pneumonia upon the root of the lung probably explained its frequent latency; the general symptoms being present, and yet the definite physical signs wanting for the first three or four days. The next difficulty was abortive pneumonia. The healthy working of the



lung was bound up intimately with that of other viscera, particularly of the stomach and abdominal organs. The high fever of sudden onset, the flushed face, the delirium, the dry cough, were all common enough from some sudden gastric upset, and in certain families were the natural reaction to some trivial informality of diet, excitement, or what not. In such there was also often some added harshness of respiration in one part or another. Another element of obscurity was the ready production of pulmonary collapse in children.

Not only did this ready occurrence of collapse tend to facilitate the attributing to the pneumonic consolidation a larger area than belonged to it, it was also inseparable from another feature of some pneumonias, namely, the absence of the physical signs when the consolidation was in reality there. This condition had been termed silent pneumonia, because, although the general symptoms were present, and with these the dulness on percussion characteristic of consolidation, the application of the stethoscope revealed nothing. Apart from the occurrence of collapse, there was a very ready explanation of silent pneumonias to be seen often in the *post-mortem* room, namely, the presence in the smaller bronchi of gelatinous casts of the pneumonic exudation. These casts were doubtless the cause of most cases of silent pneumonia, but they were equally valid causes of acute collapse of the lung, for they seldom completely filled the lumen of the bronchia, and thus readily allowed of the expulsion of the residual air, while they as readily refused the admission of any fresh intake; still there was no reason why pneumonia should not

sometimes abort, and whether such abortion was possible or not was a very important matter to settle before discussing the further question whether drugs or treatment of other kinds were effective in controlling the disease.

On the whole there seemed no doubt from a careful and even judicial scrutiny of the effects of treatment, and of the records of earlier times, and even occasionally now, of the effects of bleeding in adults, that pneumonia did abort, and possibly frequently so. In relation to these points the question arose whether such a pronounced organic change as acute pneumonia could be produced by nervous influence such as sudden shock. Dr. Goodhart had seen several cases of the kind that left little room for doubt upon the matter; the last case of the kind was a particularly interesting one.

Dr. Goodhart alluded next to pneumonia recurring often in same individual. Recently he had seen a second attack in a child of only fourteen years of age, and it was with her, as he believed it generally was, a manifestation of the rheumatic diathesis. Occasionally marked fœtor was present in acute pneumonia, fœtor such as was usually associated with gangrene of the lung. The cases had got well, twice with the supervision of empyema. The cause of the fœtor was not clear; generally it portended some unhealthy ulceration of the bronchial tubes, although, as appeared from cases of bronchiectasis, not always so.

#### THE LADY WITH THE HORSE MANE.

Under this name a young girl, aged 20, is now travelling about the world, showing to the public how richly Nature has endowed her with the ornament of

hair. She has, besides a rich *chevelure*, a mane growing out of the spine. The hair of this mane is of the same darkbrown color as that of the head, and reaches a length of about 10 inches. The place where the hair grows extends downwards for 8 inches from a point 3 inches below the hair of the head, in the middle of the spine. Not long ago this lady with the mane was presented to the Anthropological Society of Berlin, and Virchow, to her great astonishment, found that it was a pathological case, for behind the mane there was a spina bifida occulta. Several cases have been described during the last two years of hypertrichosis of some region of the spine, connected with spina bifida occulta.—*Ex.*

#### FOR DIFFICULT URETHRAL STRICTURE.

In the *British Medical Journal* Dr. McMunn recommends the following method:

In cases of difficulty, if the shaft of a silver catheter (generally of large size) or an endoscopic tube be passed quite down to the stricture, we can by this means widen out the aperture, or, more important still, alter the axis of the tube, and use the filiform instrument which it contains systematically until we hit off the opening. This will, at least, nearly always succeed in idiopathic cases.

#### THE SIGNIFICANCE OF VAGINAL DISCHARGES.

A leucorrhœa inodorous or of mild odor persisting during the climacteric, accompanied by increasing hæmorrhage, is suspicious, and demands investigation.

A leucorrhœa profuse, of peculiarly fetid odor, grumous, excoriating, appearing early or late during the climacteric,

with profuse hæmorrhage, is reasonable evidence of cancer of the cervix.

A leucorrhœa moderate in amount, ill-smelling (the peculiarly fetid odor of cancer of the cervix being absent), accompanied by hæmorrhage, suggests cancer of the corpus uteri.

A leucorrhœal discharge with hæmorrhage containing material like the washings of meat is said to indicate sarcoma.

A watery discharge, as a rule, occurring during menstruation, odorless, or of little odor, persisting, accompanied by profuse hæmorrhage, indicates fibroids; with little or no hæmorrhage, polypi.

Profuse bloody discharges coming on gradually with declining menstruation, ceasing usually with the menstrual flow, point to fibroids. Persistent profuse discharges of blood occurring spontaneously, arising from sudden exercise or coition, occurring, as a rule, after the menopause, indicate cancer.

A gradually increasing amount of menstrual flow is suspicious and needs investigating. "Post-climacteric hæmorrhages in a fibroma of the uterus of long standing, form one of the principal grounds for the suspicion of sarcoma." (Borner.)

The early recognition of malignant disease is demanded and possible prevention of the fatal exhaustion which accompanies it by the administration of drugs, and the application of those methods which, in a measure, may be supposed to offset the terrific drain on the nervous system; inasmuch as present experience shows that early removal of diseased tissue prolongs life, and the importance of early diagnosis and treatment can hardly be over-estimated.—*N. E. Med. Gazette.*  
—*Med. & Surg. Jour.*

## BOIL IT DOWN.

Just a word to those good doctors,

Who are meditating deep,

On a paper they are preparing,

Full of thoughts too good to keep—

Boil it down.

'Tis not words, but facts we're wanting;

Therefore prune and pare with pains

Your scholastic evolution

Till an essence pure remains—

Boil it down.

Let the meeting at Milwaukee

Be a feast for every soul

Who attends. And let the papers

Be as brief as Moses' scroll—

Boil it down.

You'll remember former meetings,

There were papers, less or more,

Hardly worth the time to listen—

We have all been there before—

Boil it down.

Welcome every fresh advancement,

Hail each new discovered fact,

But in writing a description

That attention will attract—

Boil it down.

And remember that discussions

Are of interest all agree;

So your paper should invite it;

Make it short as well may be—

Boil it down.

—W. E. Ward, M. D., *Journal of the American Medical Association.*

## PUREPERAL ECLAMPSIA; VENESECTION; RECOVERY.

On May 11th, 1892, I was called to attend Mrs. W., aged 27, in her fourth confinement. I found the patient in a comatose condition, cyanosed, and cold and clammy. I ordered hot-water bottles to the feet and thorough ventilation of

the room. The os was undilated in spite of very strong pains. I gave her a draught containing bromide of potassium gr.xxx and chloral hydrate gr.xx. On visiting her again three hours after, in conjunction with my father-in-law, Dr. Deeley, I found that she was gradually getting worse; the os was dilated to the size of a crown, and at the brim. Having ruptured the membranes and with great difficulty—on account of the severe rigors from which the patient was suffering, it requiring five people to keep her still—applied the long forceps, I then proceeded to deliver her of a fine healthy male child, living, at term. The placenta having been expressed and the rigors increasing in severity, the pulse very rapid—over 200 and almost imperceptible—it was decided to bleed; about a pint and a-half of thick black blood being withdrawn, with immediate relief to the patient, who never had another rigor, and made a most rapid recovery, being up and downstairs on the eighth day.

I may add in conclusion that Mrs. W. did not recover consciousness for fifty-six hours after delivery, and, when able to talk to me afterwards, informed me that all her three previous labors had been natural; and that she had never in her life before had a "fit" of any kind whatsoever.—Dr. Miller, in *Brit. Med. Jour.*

## Medical Items.

A binaural stethoscope has been patented by F. Walters & Co., of London, Eng., which has a kidney-shaped soft rubber cup to cover each ear instead of the hard ivory plug to fit into the meatus.



Dr. A. K. Bond has removed his offices and residence to 889 Park Avenue, between Biddle and Howard Sts.

From July 1st next the new rules under the Opium Act will be enforced in Burmah. In future habitual consumers in that province must register their names, and the treasury officers can issue the drug only to the people registered.

Mr. Radam, of "Radam's Microbe Killer," has been compelled to pay \$6,000 to Dr. R. G. Eccles because he denied the correctness of the analysis of his nostrum published in the *Druggists' Circular* and spoke of him as "quack and charlatan."—*American Lancet*.

Recent experiments in the Ear Hospital of London indicate that stammering is not a nervous defect only. In operations for deafness in several cases the patients were cured of stammering also, and the result is the opinion that stammering comes from some defect in the hearing.—*Exchange*.

Dr. De Bossy, of Havre, France, has reached his 100th year, is still in practice, and has been awarded a medal for his conduct during the last cholera epidemic. He was present at a dinner given a few days ago in honor of his 100th birthday. In a speech which he made on the occasion he said his father had lived to be 107 years, and he hoped to do the same.

The American Association of Obstetricians and Gynecologists holds its next meeting in Detroit, June 1st, 2nd and 3rd. Dr. L. S. McMurtry, of Louisville, is President. The Detroit members of the Association will do their part in making the meeting a success.

The annual meeting of the Medical and Chirurgical Faculty of Maryland is voted by all to have been a very satisfactory one, occupying the whole of four days with profitable and pleasant exercises. Among the advances planned for the coming year, which we hope to give in full in an early issue of the *JOURNAL*, may be mentioned the abolition of the "Sections" and the solicitation of papers on all topics from men fitted to instruct in special departments of medical thought and practice.

The death of Dr. Ely McClellan, of the Medical Corps of the Army, is reported to have taken place in Chicago on Monday, the 8th inst. Lieutenant-Colonel and Deputy Surgeon-General McClellan was conspicuous for his professional achievements with the army during the late civil war, and made many important contributions to the literature of military surgery.—*N. Y. Med. Jour.*

The *Medical Press* thinks that physicians should urge the manufacturers to devise a bicycle which could only be propelled when the rider sat erect. The attitude of the average rider is as awkward and unwholesome as possible. Look at the outstretched arms with their projecting elbows, the slouching shoulders, and backs curved like the arc of a hoop, with the head thrown back and the chin projecting. If only this sport could be conducted with a natural position of the body, it would better commend itself to both artists and physicians.—*Ex.*

At the annual meeting of the Balneological Society, Dr. Kallay, of Carlsbad, speaking of diabetes, distinguished two forms of the disease—the primary or

genuine, and the secondary or symptomatic. In the former the presence of sugar and symptoms bear a direct relation to one another and there is no organic disease. Appropriate diet and balneological treatment greatly benefit or cure such cases. In the second form symptoms are independent of the excretion of sugar and depend upon disease of some organ essential to life. Prognosis and treatment, therefore, in such cases depend upon the conditions of the primary malady.—*Ex.*

The French Society for Prevention of the Abuse of Tobacco offers a prize of books to the value of two hundred francs (\$40), with a silver-gilt medal, for the best essay containing at least four unpublished observations reported in detail (etiology, symptomatology, termination, etc.,) of affections attributable solely to the abuse of tobacco. The prize of one hundred francs, founded by Dr. Gruby, is also offered for the invention of a practical and inexpensive method of, as far as possible, destroying the deleterious principles of tobacco smoke; this is stated to be in the "interest of smokers who are inconvenienced by tobacco, and who plead that they cannot overcome their passion." Full details may be had on application to the President of the Society, 20 bis, Rue St. Benoît, Paris.

A sad and unusual accident is reported to have occurred recently in the operating theatre of one of the London hospitals. One of the surgeons was engaged in sewing up the wound after a laparotomy, and, while in the course of doing so he seems to have given a flourish to the needle in his hand, which penetrated one of the eyes of his assist-

ant. The latter continued for some moments to attend to his duties, but was afterward compelled, owing to the pain in his eye, to leave the side of the operating table and sit down on one of the benches in the theatre. As soon as the operation had been completed, the surgeon examined the injured eye of his assistant and found that the lens was lying outside the organ, the sclerotic extensively torn, and the vitreous protruding.—*Med. Rec.*

The third annual meeting of the Conference of State Medical Examining and Licensing Boards will be held in Milwaukee on June 7th, under the presidency of Dr. John H. Rauch, of Springfield, Ill. The following subjects will be discussed: 1. The Evolution of State Medical Examining and Licensing Boards: Their present and prospective influence in elevating the moral and intellectual tone of the profession. 2. Composition of Boards: (a) The desirable number of members. (b) The desirable appointing power. (c) The advantages and disadvantages of separate boards representing the different schools of practice. (3) Provisions of the various State Laws: (a) Should the possession of a diploma from a recognized medical school be a prerequisite to appearing before a board for examination? (b) What reciprocal relations should exist between boards? (c) Should teachers in medical schools be eligible to membership on State examining boards? (d) Defects in existing laws, the best law in vogue, the ideal law. 4. Methods of conducting Examinations: (a) How should the examination be prepared? (b) The scope of examinations. (c) The minimum and maximum requirements.

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## Original Articles.

### CRIMINAL ABORTION.\*

BY WM. H. PARISH, M. D.

The practice of destroying the fœtus *in utero* is not of modern introduction, but is recorded in history from the earlier nations, with the sole exception of the Jews. Aristotle and Plato defend it (*Travels of Anacharsis*, v. p. 270; *Ibid.*, iv., p. 342). It is mentioned by Juvenal, Ovid, Seneca and Cicero, and denounced by the earlier Christians. It was common in Europe through the Middle Ages and still prevails among the Mohammedans, Chinese, Japanese, Hindoos; and it has been so extensively resorted to in most of the nations of

Africa and Polynesia that it is doubtful if more have died in these countries by plague, famine, and the sword.

I will not argue before this Society the great moral criminality of what is known under the law as criminal abortion. The medical profession looks upon this crime as one of the most heinous, and as closely allied to infanticide. He who is believed to be guilty of such a crime could never be received into membership in this or any other medical society; or if a member should so far forget his high calling as to be guilty of this crime, his expulsion would quickly follow upon the presentation of adequate evidence of his guilt.

Undoubtedly many criminal abortions are produced by legalized practitioners of medicine, but in this State the law legalizing the practice of medicine is a

\*Abstract of a paper read before the Philadelphia County Medical Society, March 22, 1893.



very lax one, and in some States there is no law determining who shall practise medicine. I do not believe that criminal abortion is frequently performed, even ever so secretly, by men or women of recognized professional standing; but that it is at times produced by some such members is certainly the case, as the records of the criminal docket show. The habitual abortionist, if a legalized practitioner, is nearly always one around whom suspicion, at least, has rested, and this suspicion has been sufficient to debar him from affiliation with the worthy members of the medical profession which constitutes to a large degree the stamp of professional respectability. The medical profession draws a wide distinction between a legalized practitioner of medicine and a worthy, reputable physician. Unfortunately, this distinction is not sharply drawn by some lay minds.

A few words in reference to the justifiable production of abortion or of premature labor by members of the medical profession. That the production of delivery before the viability of the child, *i. e.*, before the end of the sixth month, is at times justifiable, is recognized in the courts and by the medical profession. But the conditions which justify such a radical procedure are not numerous.

Whenever it is necessary to terminate pregnancy in order to save the life of the mother, such a procedure is justifiable; if not thus necessary, the procedure is criminal. I grant that there is room for difference of opinion in the medical profession as to what conditions justify the production of abortion. The resort to an abortion may be reprehensible though not criminal; for instance,

when it is performed by a practitioner of medicine under the mistaken, though honest, opinion that an abortion is necessary to save the life of the mother. It is quite generally accepted that there are cases of disorders of the kidneys, or of the heart, of degenerations of the ovum—as myxoma of the chorion and polyhydramnios—and very rarely instances of uncontrollable vomiting, in which the production of early or late abortion is demanded and justifiable, because it is necessary to save the life of the mother and also because the death of the mother always involves the death of the embryo and usually that of the child approaching maturity. The authoritative works on “Medical Jurisprudence” class among the conditions justifying abortion extreme pelvic deformity. Although this statement was a proper one at one time, it is not so at present, in my opinion.

The very favorable results of the Cæsarean section, and of its modification, the Porro operation, and of symphysiotomy so recently introduced into this country—the results, I say, of these operations are now so very favorable, both to the mother and to the child, that it is time to eliminate even extreme pelvic deformity from the list of conditions justifying early abortion. The law leaves it quite entirely to the medical profession to determine what constitutes justifiable abortion, either early or late. The responsibility in this direction thus placed upon us is a very weighty one, and the privilege conferred with it should be exercised with the utmost discretion. I have, in a very few instances, felt that the physician was getting very close to criminal ground

when he produced an abortion under the plea of justifiability. For instance, a lady pregnant three months wanted an abortion produced, and so did her husband, because she, having had a very painful labor, had great dread of another labor in advanced pregnancy. They both expressed great fear that insanity would develop if her pregnancy was not terminated. Her physician asked me in consultation. We decided that an abortion was unjustifiable. She returned to her former home in a distant city and there the abortion was produced by a regular practitioner. I saw a letter from this physician in which he attempted to justify on medical grounds, not only this abortion, but also two previous ones on the same lady. His plea was that of justifiability because of apprehended insanity. Such and similar cases seem to me to quite merge into criminality. Professional opinion in reference to what constitutes justifiable abortion should be so firmly crystallized that criminal abortion could not be performed under a false plea of justifiability.

The methods of producing, or of attempting to produce, criminal abortion are numerous and widely diverse in character. Of the drugs resorted to in this country, probably the ones most frequently used, and also the ones most likely to effect the result aimed at, are the preparations of ergot and of cotton-root. These drugs act by stimulating directly the contraction of the uterus. I have known a patient to treasure up a bottle of ergot left over from her labor, and to successfully partake of its contents at the incipency of her next pregnancy. But even these drugs usually

fail to effect an abortion at any period of pregnancy. Among other drugs frequently administered are aloes and saffron. The entire list of medicines occasionally resorted to would be a long one—among them may be mentioned elaterium, corrosive sublimate, croton oil, colocynth, gamboge, cantharides, arsenic, strychnine, and other forms of mercury, pennyroyal, tansy, black hellebore, and not a few others, some of which are active poisons, others are dangerous in large quantities, and some are harmless. None of them produce abortion except occasionally, and then only through their injurious effects upon other organs or upon the general system. Some of them will produce the death of the patient without producing an abortion.

Tardieu, in his classical treatise, gives numerous cases of abortion produced, or attempted, by mechanical means. The professional abortionist usually dilates the cervix with a metallic dilator, and introduces a slender instrument into the uterus and punctures the membrane—or he may use the latter instrument without previous dilation of the cervix. Very usually, after the membranes have been punctured, he dismisses the patient and an abortion comes on in generally from three to ten days.

The more modern method of the criminal abortionist of advanced ideas is to dilate the uterus with graduated dilators, under ether, and at once to empty the uterus with all the antiseptic precaution, usually receiving the woman into his private hospital for this operation. A lady applied to one of the medical men who advertised in the New York papers. He admitted her into his hospital in New York City, and practised

the immediate removal of the ovum. She returned to Philadelphia at the expiration of a week's absence.

But sometimes the operator is ignorant and unskilled, and a great variety of instruments have been carried into the uterus: wooden skewer, crochet-needle, hair-pin, knitting-needle, a weaver's spindle, whalebone, wire, umbrella-ribs, pen-holders, catheters, bougie, sounds, tents and dilators. Tardieu speaks of the frequent use in France of what is there termed a hedgehog, which I believe is a slender instrument having near the end a number of bristles, which lie close to the handle when introduced into the uterus, but expand after introduction, and which, when rotated very effectually, break up the ovum, but which has proved disastrous also to the mother. Electricity is also effectually resorted to, one pole being usually introduced into the uterus.

Injections of corrosive or other irritant substances into the vagina are occasionally resorted to by the patient or by an ignorant abortionist. I have known a patient to produce an exfoliation of almost all of the epithelial lining of the vagina, by means of a strong solution of alum, without producing an abortion. Injections of different fluids, even water, into the uterus are resorted to, and if the membranes are largely detached or ruptured, abortion inevitably follows. In a few instances the most violent measures, such as the introduction of the hand into the uterus and attempts to drag out the entire uterus, have produced most disastrous effects.

What lesions do we find following attempts at criminal abortion? Naturally, from the variety of the means resorted

to, these are various, and may be numerous in an individual case. In one authentic case the patient herself carried an umbrella-rib into the uterus, perforated its wall, entered and passed upward and through the abdomen, through the diaphragm and into the lungs. She did not desist in her efforts until coughing of blood and troubled breathing alarmed her. She concealed her manœuvres, and the umbrella-rib was found *in situ* in a post-mortem examination. During pregnancy the physiological softening of the uterine tissue permits the easy passage of a somewhat sharp instrument through it into the peritoneal cavity, and generally with resultant fatal peritonitis. When mechanical means are resorted to, if perforation of uterus does not occur, there is usually, though not invariably, laceration—it may be a slight one—of the neck of the uterus or of the vagina. Rupture of the vagina or of the uterus has occurred from the introduction of the hand. Abscesses at various points in the uterus or in close proximity to it may follow. Blood-poisoning with local inflammations constitute the pathological conditions following many cases of criminal abortion. When drugs have been administered, gastric and intestinal inflammation may result, and evidences of such be seen after death.

It is not usually difficult to determine that an abortion is in progress; but it is by no means an easy matter to determine with certainty, from examination of patient during life, whether or not the abortion is criminal in character. Even fatal perforations of the uterus are not usually recognizable during life. The statements of the patient may give this information, but she may, and usually



does, deny that any attempt has been made to produce an abortion. Her statements, if accepted, would usually be misleading. Hence cases which recover, and the very great majority do recover, can usually be only diagnosticated as probably criminal abortions.

In the lesions found post-mortem, there is no characteristic evidence that the abortion has been a criminal one, excepting the wounds, which are usually, though not always, present in such cases as have resulted from the use of mechanical means. Even then the history of the case must be looked into, for the abortion may have been innocently produced by a reputable physician, who had failed to recognize the existence of pregnancy. Lacerations of the vulva, perineum, or vagina, may result from violent sexual intercourse, and excessive or violent sexual intercourse is not an infrequent cause of abortion in the young.

The after-treatment of criminal abortion must be according to the peculiarities of the case. If the abortion is incomplete, the indications are absolute to immediately empty the uterus and to render it aseptic. Here the expectant treatment is fraught with great danger. Such cases usually call for the utmost skill of the expert to effect the recovery of the woman.

Most frequently the underlying cause of a fatal result is septic infection or blood-poisoning. The traumatism produced is in itself usually slight and insignificant, but septic poison develops in the retained fragments of the products of conception, or is carried into the genitals by the abortionist. Blood-poisoning and the associated inflammatory lesions result.

Abdominal section with ablation of the uterus and its appendages, or of the appendages alone, may be necessitated.

When a patient suffering from a criminal abortion is sent to a hospital, it should be to one having a maternity or a gynecological ward; otherwise, the best treatment may not be secured.

If the case is about to terminate fatally the proper information should be given in order that an ante-mortem statement may be secured, and undoubtedly also no physician should give a death certificate in any case in which the death has resulted from what he strongly suspects or believes or knows to have been a criminal abortion.

I will further say, that he should not elicit or extort from the patient any information bearing upon her criminality, other than that which is necessary for his guidance in the performance of his professional duties. He must not perform the functions of a detective.

In all serious cases of abortion, especially if criminal, the physician should secure another physician in consultation for the protection of his own reputation, as well as for the welfare of the patient. Let the physician remember, also, that he can examine the patient's genitals only with her consent. If he, by an exercise of force, secures such examination, he renders himself liable to punishment by legal process.

The consideration of the measures which may tend to diminish the number of criminal abortions becomes very important in every large city, for it is believed that where the population has become concentrated, there this crime occurs with greatest frequency. The conditions or habits of life, which

diminish the number of marriages, increase the number of illegitimate pregnancies and the number of criminal abortions. But many such abortions occur in the married, and largely in proportion to the tendencies on the part of the married to indulge in expensive habits of life beyond their financial abilities.

The disgrace and shame attendant upon illegitimate pregnancy or maternity is the impelling motive on the part of the great majority of the unmarried. A recognition of the difficulties and of the disgrace attendant upon the care of an illegitimate child, on the part of its unmarried mother, impels some to secure criminal abortion.

With all, however, there is an underlying immorality, usually on the part of both sexes, which leads up to the commission of an act as unnatural as it is criminal. The preservation of the purity of morals, then, of the youth of both sexes constitutes the only efficient safeguard against the occurrence, in any community, of criminal abortion—other measures are adjuncts only.

Ultzman diagnoses vesical from renal hæmorrhage by washing out the bladder, then injecting twelve and a half ounces of a one and one-half per cent. solution of iodide of potassium. In fifteen minutes he examines the saliva for iodine. If it is found there must be epithelial defects in the bladder, *i. e.*, the hæmorrhage as well as the absorption must have taken place in the bladder, as intact vesical mucous membrane is not capable of absorption.—*Kan. Med. Jour.*

A case of Asiatic leprosy was recently discovered at Fort Wayne, Ind. The patient is a Syrian woman.—*Med. Rec.*

## TRAUMATIC TETANUS.

BY WIRT A. DUVALL, M. D.,  
OF BALTIMORE.

Mary, æt. 9 years, on Saturday, April 22nd, while playing, ran a nail into the right foot near the base of the fourth and little toes. The wound being of no apparent moment to the family, no attention was paid to it, particularly since "it did not bleed much." The child went as usual until Sunday, April 30th, on which day she complained first of a "soreness in the back of the neck;" following that, a stiffness and pain in the shoulder. Even these symptoms did not cause any suspicion on the part of the family, and not until the chill, on Tuesday, May 2nd, and the recollection that the child had not been feeling well for several days, taking little or no food, was it that the father sought medical aid.

On the evening of May 2nd, I was called, and found the patient suffering with the following symptoms: Tonic spasm of muscles, particularly back of neck; muscles of abdomen board-like at times; pupils wide open; head clear, arms and shoulders free; feet drawn to the middle line, toes folded on themselves, except the great toe, which stuck up; pulse 130, temperature slightly elevated. A history of constipation. Pain very great in epigastric region.

Not being able to get history of injury, I failed to diagnose. I ordered chloral and bromide in large doses and promised to call later, which I did, and found the punctured wound before described. I concluded I had a case of tetanus; and I feel that I was right at my first visit not to say what I thought, since the symptoms pointed to strychnia poison, also to spinal meningitis.

At the second visit the throat muscles were greatly involved; so much so that the child refused to make any attempt to swallow, as the attempt would bring on a spasm. The accumulation in the throat seemed to act as an irritant, later, and aided in making spasms. Larger doses of chloral and bromide had little or no effect. To sleep was almost impossible; thirst was intense, but little or no fever. A pint of urine was passed daily. The urine gave the following reaction: Acid, sp. gr. 1028, albumin. The examination of urine was made by my friend, W. E. Brown, Ph. G., in my presence.

On May 4th, the patient died suddenly.

I draw no conclusion, since I have seen but two cases; the other while a clinical assistant at Maryland University Hospital—a man apparently 35 years of age.

2803 Rayner Avenue.

### Society Reports.

#### CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD APRIL 7, 1893.

The 279th regular meeting was called to order by the President, Dr. William E. Moseley.

*Dr. Samuel Theobald* read a paper on RADICAL CURE OF STRICTURE OF NASAL DUCT. He said: Fifteen years ago I called attention to the ineffectual use of small probes in the treatment of lachrymal strictures. Drs. Williams and Noyes also spoke about it at the same time. To day, while using larger probes than formerly, the majority of the profession are not using as large ones as

myself. Some of my first critics said that it was impracticable to insert such probes and that I must have overlooked the anatomical arrangement of the canal. The fact was that anatomical observation was the foundation of my theory. I examined a number of skulls and cadavers and I measured the ducts by seeing how large a probe I could pass. In experiments on dry skulls I found that in seventy ducts probed the average size was 4.7 mm. in diameter. I have in my hand a pamphlet of recent date in which it is claimed that the probes cannot be passed even in the bony canals. As a matter of fact it is really easier to pass the large probes on the cadavers because there is more yielding of the tissues and you can use more force than is possible in the dry skull without breaking the bones. Of ten subjects examined I found the average size of the duct to be 4.47 mm. in diameter, the largest being 7 mm., and the smallest 3 mm., which is equal to a No. 12 probe. Why should we use such large probes? Because the small ones will not produce permanent benefit. De Schweinitz in his latest work ('92) speaks as if he still used Bowman's probes, but lays no stress upon the use of large ones and gives a doubtful prognosis. Fuchs in his new work ('92) does not go beyond a No. 6 and as the prognosis says: "Even in the most favorable cases, treatment lasts for many weeks and a recurrence is the rule." After an experience of fifteen years with their use I can say that there is no class of cases which I approach with more confidence of a successful issue. Of course when we have to deal with a severe case of nasal catarrh or ozæna, we can not expect the most



marked success. Many of the cases I see have been treated before by small probes. I have watched this treatment for years and have seen no relapses in persons who were discharged as cured. I believe nearly all the relapses were in patients who have for one reason or another ceased before treatment was completed. I invariably endeavor to avoid beginning with the small probes, for it is so easy to produce with them a false passage. I prefer to begin with a No. 5 or 6. There are three kinds of tissue in this duct—mucous membrane, periosteum and bone. If the closure is due to simple hypertrophy of the membrane it will probably be relieved by simple collyria. I have never met with blepharorrhœa of the lachrymal sac caused by severe ophthalmia. It is almost invariably due to extension of catarrh from the nose. My method of operating is first to anesthetize with cocaine and then pass a small probe, No. 2 usually, through the puncta and canaliculus to look for, and finding it to facilitate the entrance of the probe-pointed canaliculus knife into the sac. Having slit up the canal I then pass a No. 5 or No. 6 probe or a smaller one if I fail with these. I anoint the probes with vaseline containing ten per cent. cocaine. Having surely entered the sac we need not hesitate to use force in passing the stricture. I have never seen any serious consequences. Rarely I have had while using the small probes an ecchymosis of the lid and once or twice slight inflammatory reaction. I do not think it advisable to probe daily unless compelled to for want of time. It may excite too much inflammation. Every other day is my custom. I increase by number each time,

skipping a number if very freely passed or dropping back one if too tight. In two-thirds of all cases, including children, I have used No. 16. Having reached the largest I intend to use I then increase the intervals. The only objection I know to the treatment is that the duct may remain too pervious and air passes freely when the nose is blown, but such inconvenience is, I think, very small. In addition to probing I always prescribe collyria to be used three times daily. The most useful ones I have found to be a solution of bichloride of mercury 1-12000. Next to that I prefer a solution of alum, ten grains to the ounce. I do not attack a fistula or carious bone; they soon take care of themselves if the passage is open. Patients may be taught to probe themselves with the larger probes. Strictureotomy has never appealed to me as rational treatment nor have I ever had any reason to destroy the lachrymal sac.

*Dr. Harlan* said that about 12 years ago he began to investigate *Dr. Theobald's* probes. Experiments on the cadaver showed him that the largest one, equal to a No. 32, could be passed in most cases, and the second size in all cases without difficulty. At the Presbyterian Eye and Ear Hospital all the cases of stricture at that time were turned over to him. He used the probes and found them particularly satisfactory. He dilated many up to No. 16 but with not quite as good results as *Dr. Theobald* obtained. He had most trouble with the old cases, probably because the first probe had not been properly passed and either had not entered the sac or had made a false passage or had injured the periosteum. Cases in which he could

hear the scraping against the bone were most unfavorable and often did not remain open after a No. 16 was used. He has made it a rule not to go beyond No. 12. He still finds some cases closing up again. Like Dr. Theobald, he begins with No. 6. He has found much satisfaction in certain cases by the use of a lead style. He reported a case which had been probed up to No. 16 and in which a style had been used, but still the stricture recurred at intervals. In a second case where there was no punctum, he made one and probed to No. 10. There was recurrence after a few days. The treatment was repeated with the same result. A style was used but the result was the same. Cases where there is diseased bone, opposing raw surfaces, or stricture at the extreme lower end of the duct, he has found hard to treat. For the large majority of cases he has only words of praise for Dr. Theobald's method.

Dr. Bernstein said that before going abroad he had treated two cases up to No. 12 and now after two years he finds them still perfectly well. He had taken a set of the probes abroad with him and had fairly astonished the German physicians with them.

Dr. Wicker when slitting up the canaliculus attempts to pass the knife as far as possible to cut any stricture.

Dr. Theobald considered the use of collyria in addition to probing an important point. He has rarely found any difficulty in passing the same sized probe after the lapse of a week or two. Roughness of bone does not lead him to change his prognosis. Such cases do require a longer time, but he expects satisfactory results.

H. O. REIK, Secretary *pro tem*.  
810 Madison Avenue.

## CALVERT COUNTY MEDICAL SOCIETY.

A special meeting of the Calvert County Medical Society was held at Prince Frederick, Md., May 2, 1893. Dr. John F. Ireland, Chairman; Philip Briscoe, Secretary. Those present were: Drs. Chaney, Ireland, Dawkins, Jones, Williams, Paddy, Sedwick and Briscoe. The object of the meeting having been stated by Dr. Jones to be to take suitable action in commemoration of the death of Dr. S. B. Hammett, who died January 21st, 1893. After some eulogistic remarks by Drs. Briscoe and Chaney, on motion a committee was appointed by the chairman to draft suitable resolutions. The Committee, Drs. Briscoe, Dawkins and Paddy, reported the following resolutions, which were read and adopted: "Whereas, In the order of an all-wise Providence our beloved friend and brother, Dr. S. B. Hammett, has been removed by the hand of death.

Be it *Resolved*, That as a member of this society we mourn the loss of an earnest, energetic, able and loyal supporter. As associates we grieve over the departure of a faithful friend and brother, and as a consultant we miss a capable, enthusiastic and impressive physician.

*Resolved*, That in this hour of sorrow over Dr. Hammett's departure, we recall with pleasure as foremost among his qualities of mind and heart his warm sympathy with those suffering in mind, body or estate, his deep grief over the loss of one under his professional care. And trusting from so noble an example we may draw an inspiration which shall nerve us to more cheerful sacrifice of personal ease, and sordid ambition in



the interest of suffering humanity about us.

*Resolved*, That to his aged mother who has been bereft of a noble son who was the pride of her life, and also has many friends, we hereby offer our profound condolence.

And be it further *Resolved*, That these resolutions be spread upon the minutes of this meeting and that a copy be sent to his family, and a copy to each of the county papers and to the MARYLAND MEDICAL JOURNAL for publication.

P. BRISCOE, John T. Dawkins and Estess Paddy, Committee.

On a motion, the Society adjourned.

DR. JOHN F. IRELAND, Chairman,  
P. BRISCOE, Sec'y.

#### THE PRESENT POSITION OF GALL-BLADDER SURGERY.

Czerny, after a general consideration of gall-bladder surgery, presents the following conclusions:

1. Gall-stones require operation, if they cause frequently repeated or lasting trouble.

2. Empyema of the gall-bladder imperatively demands operation; as does hydrops, if it gives serious trouble.

3. The typical operation for gall-stones consists in incision, removal of the stones, and suture of the gall-bladder; in this, however, the abdominal wound should be drained for a short time.

4. If the cystic duct is closed, if the gall-bladder is the seat of inflammation, or the contents are greatly altered, then a temporary gall-bladder fistula must be made.

5. Extirpation of the gall-bladder is

indicated only in cases of severe inflammatory carcinomatous involvement.

6. When the ductus choledochus is closed, the operation is absolutely indicated, if the strength of the patient will permit. If one does not succeed in removing the stone or obstruction, then it is recommended to produce a fistula between the gall-bladder and duodenum.

7. The best incision for gall-bladder is an J shaped cut; the vertical limb lies in the linea alba, and the horizontal part runs towards the right, just below the level of the umbilicus.

8. The danger to life of gall-stone operations will be probably less than in operations for vesical calculus.—*Med. & Surg. Jour.*

The total number of students in all four faculties of the University of Vienna during the winter semester of 1892-93 was 5,995, of whom 2,879 belonged to the medical faculty. Of these, 2,461 were Austro-Hungarian subjects and 418 were foreigners. The largest contingent of the latter came from Russia, which was represented by 94 students, the United States standing second on the list with 89, and England being well down towards the other end with 11. Spain was the only country unrepresented. Asia sent 3 students, while Africa was conspicuous by its absence. The teaching staff comprised 57 Professors, 70 *Docenten*, and 223 Assistants.—*Ex.*

A bill now before the Pennsylvania Legislature forbids the exhibition of monstrosities at public places like the Museum.—*Med. Rec.*



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A. K. BOND, M. D., Editor.

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BALTIMORE, MAY 27, 1893.

Editorial.

IMPORTANT QUARANTINE  
ADVANCES.

The difficulty of stamping out cholera when once numerous cases have been landed upon our shores or have even been received at our quarantine is too well known to need comment. No thoughtful citizen would desire to have the horrible scenes of last summer in New York harbor repeated.

Thanks to the new quarantine law passed by Congress at its last session, the war against infection will now be transferred to foreign ports, and active measures of inspection and exclusion will be taken by sanitary agents of our national government, looking to the prevention of the shipping from those ports of infection-bearing freight or passengers. These measures, if faithfully carried out, ought to greatly aid in the protection of our country against the invasion of cholera which threatens

to occur during the coming warm season.

Another important advance in quarantine is the establishment of uniform quarantine laws throughout the continent of Europe. At the recent sanitary conference held in Dresden, in which France, Germany, Austria, Italy, Belgium, the Netherlands and Russia participated, a common system of quarantine methods was adopted, very like the excellent system now enforced in England. Says the daily press report:

"Combined and moderate measures compatible with the necessities of international intercourse and commerce are to be substituted for the hap hazard and arbitrary action of individual States and local authorities. The convention has special reference to cholera, but its provisions can be given general application. There is to be, in the first place, an interchange of official information between the signatory powers. The appearance of cholera in any one of them is to be notified to all, together with the steps taken to cope with the epidemic. Then certain general rules are laid down for all to observe. As respects imports from infected countries, it is agreed that only old clothes, bedding, soiled linen and rags shall be immediately liable to exclusion. The importation of other articles shall be prohibited only under special regulations. The convention recognizes the futility of land quarantines, and brings within fixed limits the power to quarantine arrivals by sea.

Ships arriving from ports infected with cholera are to be treated as infected only where cases have actually occurred on board during the last seven days of the voyage. Ships are to be treated

as under suspicion when cases have occurred aboard prior to the last seven days. Other ships, though from infected ports, if free from suspicious cases, are to be allowed to enter, but are to be subject to the right of local authorities to impose upon arrival reasonable measures of disinfection and a term of medical observation not to exceed five days from the day of sailing. A like term of five days, reckoned from the date of landing, is to be applied to the isolation and observation of passengers and crews of ships actually infected or suspected."

We may expect that much greater success in combatting epidemics in Europe will follow the adoption of these wise and temperate measures; and as the entrance of great epidemics to America is chiefly if not wholly through Europe, a corresponding increase in the safety and immunity of America may be anticipated.

## MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

95TH ANNUAL SESSION, HELD IN  
BALTIMORE.

FIRST DAY, TUESDAY, APRIL 25TH.

The Faculty was called to order by the President, Dr. L. McLane Tiffany, at 12.30 o'clock, a large number of members being present.

The proceedings were opened with prayer by Rev. Arthur C. Powell, D. D.

The hours for sessions were fixed at from 12 to 3 P.M. and 8 to 10.30 P.M.

The President read his address on the "Treatment of Neuralgia of the Trigeminal Nerve; with Special Reference to

the Relief Obtained by Excision of the Gasserian Ganglion."\*

The Section on Surgery being called, Dr. F. C. Bressler read a volunteer paper entitled "A Case of Acute Infectious Periostitis of Fibula, with Exhibition of the Patient." The paper was discussed by Dr. Wm. H. Welch.

Dr. W. B. Platt read a paper on "Plastic Surgery of the Face," illustrated by cases; and likewise exhibited a truss for hernia in infants, composed of skeins of white worsted, and explained its method of application. He had, in a brief experience, found it very satisfactory.

The Section on Practice of Medicine being called, Dr. Charles O'Donovan read a paper entitled "Is Baltimore City Supplied with Good Drinking Water?" (See JOURNAL, page 67.)

The Faculty then adjourned until the evening.

An invitation was received at this session, through Dr. Thomas H. Brayshaw, from the Anne Arundel Medical Society, that the next semi-annual meeting of the Faculty should be held in Annapolis, Md. As required by the Constitution, the invitation was referred to the Executive Committee.

FIRST DAY, TUESDAY, EVENING SESSION.

At 8 P. M., the First Vice-President, Dr. John W. Chambers, called the meeting to order.

Dr. Wm. F. Lockwood presented a paper entitled "Notes on Measles from 79 Cases in an Institution." The paper was discussed by Dr. Norment.

Dr. Wm. T. Howard, Jr., then read

\*We hope to give this paper in full in a coming issue.

a report of "A Case of Diphtheria of the Heart." It was discussed by Drs. Wm. H. Welch and Joseph Harris.

Dr. George H. Rohe next read a report on "The Hypodermic Injection of a Solution of Magnesium Sulphate as a Purgative."<sup>†</sup>

A paper upon "Calomel" was read by Dr. Edward Anderson.

Dr. J. S. Fulton offered a clinical study of "Subcutaneous Emphysema Complicating Measles." This rare occurrence was discussed by Dr. Wm. H. Welch.

A short paper by Dr. W. A. B. Sellman, on "The Treatment of Metritis and Endometritis by the Electrical Current," was discussed by Dr. H. A. Kelly, who then presented a series of stereopticon illustrations of his operating rooms and furniture and the lesions and repair of certain gynecological ailments.

The Faculty then adjourned till Wednesday noon.

#### SECOND DAY, WEDNESDAY.

The exercises of this day's afternoon session began with a paper by Dr. A. K. Bond, on "The Present Status of Drug Therapeutics as Applied by the General Practitioner."

The special subject appointed beforehand for discussion to enliven this annual meeting was then taken up as mentioned on page 52 of a former issue. Puerperal Infection furnished its exceedingly practical theme. The referees were Drs. J. E. Michael, on *Ætiology* and *Prophylaxis*; J. Whitridge Williams, on its *Bacteriology*; T. A. Ashby, on

Clinical History and Treatment. The co-referees were Drs. Wilmer Brinton, W. S. Gardner and L. E. Neale. All of these gentlemen responded fully, and the discussion had to be completed on the following day.

#### SECOND DAY, EVENING SESSION.

This session was occupied by the reports of the officers of the Faculty, touching its progress during the past year. Very satisfactory progress was shown in many respects. The Faculty is growing in numbers, influence and literary and scientific attainment. Its full growth is hindered by deficient financial support and the lack of a suitable home.

The work of the State Examining Board was touched upon on page 52 of a recent issue.

The subject of the licensing of midwives, with the establishment of suitable requirements as to intelligence and skill, was taken up.

The Memoir Committee reported three deaths during the year—Drs. John P. Van Bibber, W. Chew Van Bibber, and A. S. Wagner; a short sketch of the life of each was given.

About 120 new members were listed during the year.

#### THIRD AND FOURTH DAYS, THURSDAY AND FRIDAY.

The last two days of the Faculty's session were full of interest. A thoughtful paper was given by Dr. William B. Canfield, on Some Clinical Aspects of Immunity, in which he laid especial stress on second attacks of infectious diseases.

<sup>†</sup>Messrs. Sharp & Dohme, of this city, have since prepared compressed tablets for hypodermic use by physicians, as advised by Dr. Rohe, containing respectively 1½ grs. and 1 grs. of magnesium sulphate.



Dr. E. M. Schaefer presented a bright and humorous paper on "An Ounce of Prevention, or What the Poor Man can Do to Escape Cholera—and the Doctor."

General Paralysis in the Negro Race was then ably discussed by Dr. Henry J. Berkley.

The Annual Oration was delivered according to appointment on the evening of the third day, before a crowded audience of attentive physicians, by Dr. Reginald H. Fitz, of Howard University, on Intra-Peritoneal Hæmorrhage.

This was followed by a banquet in the Faculty Hall at which visiting physicians were the guests of the Faculty. The evening was spent very pleasantly by all who participated.

The last day found much business still before the house; two full sessions being held.

Dr. J. C. Hemmeter presented a consideration of the "Biological Aspects of Blood and Blood-vessels," which was discussed by Dr. Wm. H. Welch.

Dr. Alex L. Hodgdon then read a paper on "Hereditary Influence; its Relation to Mental Disease;" dwelling at some length on maternal and paternal "impressions" and eliciting a vigorous discussion by members of the Faculty.

"Syphilis as a Cause of Nervous Disease" was the subject of an elaborate paper by Dr. Henry M. Thomas.

"A Case of Periodical Insanity Associated with Menstrual Trouble" was reported by Dr. B. D. Evans.

A consideration of the Diagnosis of Asiatic Cholera, by Dr. Wm. H. Welch, excited much attention and considerable discussion.

Other papers were presented on Suppurative Inflammation of the Temporal

Bone, by Dr. Herbert Harlan; The Causation of Inflammation, a review by Dr. Harry Friedenwald; Tuberculosis of the Pharynx, by Dr. John R. Winslow; Acute Glaucoma after Cataract Extraction, by Dr. Frank M. Chisolm; and three volunteer papers on a Clinical Study of 35 Cases of Epidemic Cerebro-spinal Meningitis, with special reference to Eye-Symptoms, by Robert L. Randolph; Hypertrophic Rhinitis as a Cause of Asthenopia, by Dr. E. J. Bernstein; and a Study of Two Cases of Paroxysmal Sneezing, by Dr. Wm. T. Cathell.

The last evening closed with election of officers; a full list of whom is given in our issue of May 20th.

### Correspondence.

#### CHICAGO POST-GRADUATE MEDICAL SCHOOL.

*Editor Maryland Medical Journal:*

In the announcement of the summer course of lectures at the Chicago Post-Graduate Medical School by Lawson Tait, of Birmingham, Reginald Harrison, of London, Schauta, of Vienna, Price, of Philadelphia, etc., by an unfortunate mistake of the printer I am placed as a resident of New York and my subject is not given. The topics discussed by myself will be embraced in the title: "Some Achievements in Intracranial Surgery;" and my remarks will be based entirely upon my personal experience, which in number and variety of cases is more extensive than that of any other American surgeon. Inasmuch as this work has been done in Kansas City, may I not ask you to make note of correction as to my field

of labor? Thanking you in advance for your courtesies in so doing, I am

Very truly yours,

EMORY LANPHEAR.

### Pan-American Congress.

The Section in Marine Hygiene and Quarantine has been organized as follows:

Honorary Presidents: Dr. Lino Alarco, Lima, Peru; Dr. Henry B. Baker, Lansing, Mich.; Dr. Cardenas, Managua, Nicaragua; Dr. J. J. Cornilliac, St. Pierre, Martinique, F. W. I.; Dr. Felix Formento, New Orleans; Dr. H. B. Horlbeck, Charleston; Lieutenant-Colonel Amalio Lorenz, Sub-inspector of second class Spanish Navy, Havana; Dr. F. Montizambert, Quebec, Canada; Dr. Francisco Nunez, St. Tecla, Salvador; Dr. Juan Ortego, Guatemala, Guatemala; Dr. Joseph Y. Porter, Jacksonville, Fla.; Dr. John Pringle, Kingston, Jamaica; Dr. Juan J. Unoa, San Jose, Costa Rica; Dr. J. Mills Browne, Surgeon-General United States Navy. Executive President: Dr. Walter Wyman, Surgeon General, United States Marine Hospital Service, Washington. Secretaries: Dr. S. T. Armstrong (English-speaking), 166 West Fifty-fourth Street, New York; Dr. G. M. Guiteras (Spanish-speaking), United States Marine Hospital Service, Washington. Advisory Council: Dr. H. M. Biggs, New York City; Dr. John C. Boyd, United States Navy; Dr. H. R. Carter, Norfolk, Va.; Dr. W. M. L. Coplin, Philadelphia; Dr. A. G. Clopton, Galveston, Texas; Dr. C. G. Currier, New York; Dr. S. Durgin, Boston; Dr. Seneca Egbert, Philadel-

phia; Dr. George Homan, St. Louis; Dr. W. T. Jenkins, New York; Dr. J. F. McShane, Baltimore; Dr. G. H. F. Nuttall, Baltimore; Dr. S. R. Olliphant, New Orleans; Dr. Dabney Scales, Mobile; Dr. R. M. Swearingen, Austin, Texas.

The executive president desires to call the attention of all members of the medical profession that are interested in the topics pertaining to this section to the regulation of the congress, that contributors are required to forward, not later than July 1st, to the secretary of the section, abstracts, not to exceed six hundred words each, of the papers they propose to present before the section.

The topics that will be considered by this section are as follows: 1. The hygiene of vessels, commercial or naval, including the questions of ventilation, heating, sanitary arrangements, the disposal of cargo so as to facilitate disinfection, food supply, etc. 2. The medical officers of passenger vessels; methods for their selection, duties, etc. 3. The vital statistics of seamen and firemen. The question of the medical examination of crews preparatory to shipping. 4. The supervision of vessels by government medical inspectors at ports of arrival and of departure. Code of rules for handling an epidemic disease that breaks out on shipboard. Disinfection of passengers and crew during a voyage. Location and arrangement of ships' hospitals. 5. Epidemic and exotic diseases propagated by shipping. What diseases should be quarantined. Responsibility of nations for epidemics; India for cholera, South America for yellow fever. Can a feasible plan be devised to totally exterminate cholera? International inter-



vention to prevent the propagation of cholera or other epidemic diseases by pilgrimages or immigration. 6. International uniformity in quarantine regulations. Should quarantine officers be notaries public? 7. Arrangement of detail and equipment of quarantine stations: *a*, inspection stations; *b*, local quarantine stations; *c*, refuge stations. Methods for handling infected or suspected vessels. Interstate and island quarantine; sanitary cordons; camps of refuge; camps of probation. Recent improvement in hospitals for infectious diseases. Railroad inspection and quarantine. Length of time vessels should be held in quarantine. Conditions that should determine proclamation of quarantine against a country. Under what requirements may passenger traffic be carried on between a port infected with yellow fever and a southern port of the United States during the summer with the least obstruction to such traffic? What merchandise should be considered as requiring treatment if shipped from a port or place infected with cholera, yellow fever, or small-pox? 8. Methods of disinfection: *a*, persons; *b*, baggage; *c*, cargoes; *d*, vessels. Recent improvements in quarantine appliances; steam chambers; sulphur furnaces. Liquid sulphur dioxide as a disinfectant. Treatment of ballast: water; solid. What time should an infected vessel be detained in quarantine?; *a*, for cholera; *b*, for small-pox; *c*, for typhus fever; *d*, for plague; *e*, for yellow fever. Methods of disposal of the bodies of those that die while in quarantine.

The Illinois State Medical Society held its forty-third annual meeting at Chicago, May 16, 17 and 18, 1893.

### Medical Progress.

#### WAS IT DIPHTHERIA OR CROUP?

Describing an interesting case of membranous inflammation of the respiratory passages followed by fatal meningitis, Dr. F. A. Morrison (*Med. Fortnightly*, May 15th), writes:

Have we here reported a case of diphtheria or true croup of the nose? In favor of the former view is the prevalence of diphtheria in the city, the ultimate distinct, though slight, glandular enlargement, and the fatal result.

As against this, the non-appearance of the disease in either of the other four children of the family, who were constantly with the patient during his illness. Next, the general low temperature, good pulse and absence of all symptoms of exhaustion or systemic infection.

Then the character of the membrane—I was fortunate in having, at the same time, three cases of undoubted nasal diphtheria under treatment, and had an excellent opportunity of noting the points of difference. Never before had I seen the classical clinical distinction of the one being incorporated with the cells of the mucous membrane, and the other simply laid on, so sharply defined.

Here the absolute absence of odor and the unchanging pearly white color of the membrane, were in marked contrast to diphtheria. The same can be said of the lack of hæmorrhage after separation of the deposit. The tremendous faculty of membrane-reproduction was one of the marked features of the case.

If this be admitted to be an example of non-diphtheritic rhinitis, one must be more guarded in prognosis than is indicated by text-books. We are taught by



those who recognize the duality of the diseases that croupous rhinitis exhibits little tendency to spread. In the case just described, I have no doubt that it spread to the antrum of Highmore, lachrymal sacs, the rudimentary frontal sinus, and eventually to the meninges, possibly through the openings in the cribriform plate of the ethmoid.

The terrific tendency to reproduction leads one to speak of it in this particular as almost malignant. Truly, if this be an example of the behavior of croupous membranes in other localities, we have little to encourage us in laryngeal croup.

The treatment employed during the course of the disease was in the nature of general support to the system by tonics and stimulants, together with local solvents and antiseptics. Locally, various applications were made. Destruction of the membrane *in situ* by tincture of iron or lactic acid gave negative results. Mechanical removal of the membrane, followed by peroxide of hydrogen, corrosive sublimate, sulphurous and lactic acids, or insufflation of iodoform and boric acid, all proved unavailing in the nose. In the mouth dilute sulphurous acid seemed to control the deposit.

#### EPILEPSY IN CHILDREN.

In a recent discussion before the New York Academy of Medicine (*Archives of Pædiatrics*, May), Dr. J. Lewis Smith said he had seen a large number of cases of epilepsy and eclampsia in children, and he believed it was a rule that epilepsy beginning early was preceded by one, two, three, or more attacks properly of the nature of eclampsia, these first attacks usually being attended by fever and disturbance in the digestive organs. By proper treatment begun early or while

the attacks were essentially those of eclampsia, he thought we could obviate a life of epilepsy.

As to the treatment of eclampsia, his experience had extended to a time antedating bromides and chloral, when he had to rely on reduction of the temperature, opening the bowels, foot bath, assafoetida, etc., and he had spent hours over cases treated by these means. But since bromides had come into use, he would not treat a case without them, beginning the administration of bromides from the time of his arrival. He regarded bromides as efficient remedies against eclampsia as well as against epilepsy. Dr. Smith remarked with regard to the medulla oblongata being a convulsive centre, that it was known convulsions could occur in anencephalous monsters.

The Chairman asked Dr. Smith whether he agreed with Dr. Dorning in giving large doses of chloral, and Dr. Smith replied that he did not. When called to a child a year old in convulsions he would first give twelve grains of bromide of potassium, repeating every five minutes, and if the convulsions did not cease in twenty minutes he would give hydrate of chloral, but not more than three to five grains per rectum, sometimes having to repeat this dose.

#### SHAKING PALSY.

Dr. Dana, of New York, recently read a paper before the Philadelphia Neurological Society, of which an abstract is given in the *Jour. Ment. & Nerv. Dis.*, May, as follows: In the clinical part of his paper, Dr. Dana gave the results of examinations of the blood, using Ehrlich's stains; these showed the presence of a progressive chlorosis, but not anæmia; also some changes in the myelocytes. A number of sphygmographic tracings of

the pulse were shown, and the conclusion reached, that there is in paralysis agitans, a general vaso-motor paralysis affecting the skin, viscera, nerves, and lower nerve-centres, but not the brain.

In the pathological part the author first went over the literature of the pathological anatomy of paralysis agitans, giving a summary of the findings in all authentic cases. The number of available cases was found to be only fourteen. The findings in late years were much more uniform and definite. The author then reported his own two cases, and gave the results of his microscopical examinations. These, in brief, revealed the presence of great vascular dilatation, connective tissue, proliferation, and nerve-cell degeneration. The lesions were most marked in the central gray of the cord, and the vagus, and glossopharyngeal nuclei. The brain cortex, internal capsule, and basal ganglia were normal.

Dr. Dana believed the vascular and connective tissue changes to be primary, the nerve-cell changes to be secondary. He thought the process resembled a low grade of chronic inflammation. At any rate he considered the primary cause of paralysis agitans to be a toxine of autochthonous or microbic origin. Shaking palsy was a toxine disease. The primary seat of the trouble was in the spinal cord, more particularly in the central and anterior grey matter, supplied by the central arteries.

Dr. Dana thought that the time was past when paralysis-agitans could be called a functional disease without a morbid anatomy. The most recent and thorough post-mortem studies showed results in conformity with those reported

by the writer. The practical conclusions in regard to therapeutics were that remedies for the disease in its earlier stages should and probably would be found. Such remedies would be of the character of anti-toxine or diathetic drugs modifying metabolism and promoting excretion. Some results of the author's therapeutical experience were given.

#### • THE DRIP-SHEET.

In a recent address before the New York Academy of Medicine (*Medical Record*) Dr. Weir Mitchell gives the following directions for the use of this agent by persons needing the modified rest-cure:

What I dread most at the start, in all cases for rest, is grave insomnia. Whether it be accompanied by a state of mild mental excitement, such as we all know, or is a pure incapacity to go to sleep, or to stay asleep, or whether it be in popular medical belief a congested state, I am apt at once, in bad cases, to use twice a day lithium bromide, at first in 30-grain doses, at noon, at 6 and 9 P. M., given in the malt or not, and soon decrease grain by grain. If I want a positive aid at bedtime, I prefer sulfo-nal in hot water. But of greater value are some of the hydro-therapeutic devices—and best of these is what is known, or not known, as the "drip-sheet." Just how this is to be given is of the utmost importance. The following memoranda, which I shall not read to you, but shall ask you to read hereafter, must answer to show how careful one must be, in my opinion, as to these details. I give it here in brief, much as I do to the patient not under the immediate care of a nurse. I cannot help adding that sev-

eral of the most useful of the water processes are neither taught in our schools, nor so accurately in hydro-therapeutic text-books as to be of much value to the general practitioner.

*Memoranda for use, at bedtime, of drip-sheet.*—Basin of water at 65°F. Lower the temperature day by day by degrees to 55°F., or to still less. Put in the basin a sheet, letting the corners hang out to be taken hold of. The patient stands in one garment in comfortably hot water. Have ready a large, soft towel and iced water. Dip the towel in this, wring it, and put it turbanwise about the head and back of the neck. Take off night-dress. Standing in front of patient—the basin and sheet behind—the maid seizes the wet sheet by two corners and throws it around the patient, who holds it at the neck. A rough, smart, rapid rub from the outside applies the sheet everywhere. This takes but two minutes, or less. Drop the sheet, let the patient lie down on a lounge upon a blanket, wrap her in it, dry thoroughly and roughly with coarse towels placed at hand. Wrap in a dry blanket. Remove ice wrap; dry hair; put on night-dress. Bed, the feet covered with a flannel wrap.

If all this seems to you as you read it too absurdly minute, I shall feel some regret. Yet believe me, it is worth the trouble, and the drip-sheet is a remedy past praise. If it fail, a pack may succeed, but this is more familiar to you. I doubt if the use of the drip-sheet is as well known.

An effort is being made in Hungary to erect an international memorial to Semmelweis.

## Recommendations of Therapeutic Agents.

### THE THERAPEUTICS OF TERRALINE.

After having made a thorough trial of Terraline (a purified petroleum) under a number of varying conditions and over a somewhat extended period of time, I desire now to give to my professional friends some of the conclusions to which I have arrived. In doing this, I feel that I am performing a service to the medical profession at large as well as paying tribute to a most valuable therapeutic agent.

Terraline stands without a peer to-day in the treatment of all inflammatory conditions of the respiratory tract, and I cannot recall a single instance in which it failed to produce all that is claimed for it. I have especially noticed the good results following its use in the following conditions:

Capillary bronchitis.—In capillary bronchitis, administered in teaspoonful doses, it modifies the cough, increases the expectoration, and generally improves the patient.

Phthisis pulmonalis.—In phthisis pulmonalis I have always found Terraline superior to cod-liver oil. It does not simply palliate the cough; it allays the pulmonary irritation, improves the digestive and assimilative powers, and overcomes the repugnance to food so often observed in this disease. I invariably prescribe it with creosote as follows:

R.—Creosote . . . ʒiiss,

Terraline . . . ʒxii. —M.

Sig.—One teaspoonful three or four times daily.

This can be modified by prescribing double the amount of Terraline and administering two teaspoonfuls at a dose.



Chronic bronchial catarrh. — In chronic bronchial catarrh it has never disappointed me. In fact I have received the most flattering and most positive results, exceeding often my highest expectations. In the croupy coughs of children, and in croup itself, it is prescribed with the greatest benefit.

A reconstructive.—Terraline is a reconstructive and tissue builder of great power. Some months ago I prescribed it in a case of general anæmia in an excessively chlorotic girl. The improvement was soon marked and progressive. She used the remedy three months and gained in weight five and one-half pounds each month.

Weak stomachs and fastidious patients. —As Terraline is so easily digested and is entirely tasteless, it can be administered indefinitely to the weak stomach without creating a repugnance to its use, a most decided and important desideratum. Children and fastidious females take it readily, for, as stated, it is without taste, it is odorless, and it does not produce eructations. In conclusion, I would say that in Terraline we have a product of purified petroleum, without the disagreeable taste and odor of crude petroleum, and yet with all the medicinal qualities fully preserved.—Chas. Kelley Gardner, M. D., Huntington, W. Va.

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### Medical Items.

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The Board of Health of the City of Mexico has prohibited the use of salicylic acid, or any of its derivatives, in beverages or food of any kind. After October all packages containing it will be destroyed.—*Ec.*

"The 'bellyband,' made in summer of light merino and in winter of flannel, should be continued during the first year or eighteen months."—J. Lewis Smith.

The death of Professor Johann Schnitzler, the famous laryngologist and rhinologist of Vienna, is reported. Schnitzler was fifty-eight years of age. His death will be regretted by the many Americans who have enjoyed his able instruction.

In incontinence of urine in childhood, Dr. J. E. Powers recommends the use of collodion. The prepuce is drawn over the glands and collodion is smeared on by means of a camel's-hair pencil. In contracting it draws the edges of the prepuce closely together, effectually sealing the passage. A patient after one lesson can apply it himself. A cure usually results in a couple of weeks. —*North Carolina Medical Journal.*

Medical journals are reporting the case of a child poisoned with strong tea. Some commentators point out that both coffee and tea contain the same poisonous alkaloid, and warn the reader against the use of coffee. The facts are that tea may contain four times as much caffeine (theine) as exists in coffee. Thus it would require four times as much coffee as tea to poison a person. Then the case reported is of a child and not an adult.—*Med. Fortnightly.*

The eighth annual meeting of the Association of American Physicians will be held in the Army Medical Museum and Library Building, at Washington, D. C., on May 30, 31, and June 1, 1893. A large programme has been pre-

pared which will be opened by the address of the President, Dr. A. L. Loomis, of New York. There will probably be time at the meeting for the reading of a few more papers than have already been contributed; members who are desirous of filling these vacancies with papers will send the title of them to the Secretary, Dr. Henry Hun, 149 Washington Avenue, Albany, N. Y. The constitution provides that papers shall not exceed thirty minutes in the reading.

Commercial glycerin, so-called, is liable to be contaminated by the presence of arsenic, and a case of poisoning in which the sophisticated character of the glycerin was supposed to be responsible has been reported by Jaroschi to the Prague Medical Society. The patient, a man, had been induced to take large quantities of glycerin; and shortly afterwards became seriously ill, suffering from vomiting, painful defecation and pains in the calves of the legs; but under suitable treatment, the glycerine of course being discontinued, the patient was not long in recovering.—*Am. Therapist.*

Calcium sulphide has several times been recommended in phthisis and not a few cases have been successfully treated with this drug. Perhaps its use was first suggested by the apparent success that followed the first trials of the Bergeon method of rectal insufflation of sulphuretted hydrogen gas, or it may be that the known power of calcium sulphide of inhibiting the formation of pus led to its use. At any rate the drug does best in those cases of phthisis where expectoration is profuse. It should be given at short intervals, say every two hours and in doses of half a grain,

unless disagreeable symptoms are produced. This method of administration interferes somewhat with its combination with strychnia and arsenic in a pill as recommended by some writers.—*Ex.*

It is announced in the daily papers that Dr. Thomas Alexander Lynch died at his home, in the second election district of St. Mary's county, aged seventy years. Dr. Lynch was a prominent figure in St. Mary's affairs. He was a candidate on the democratic ticket for the State Senate in 1878, and a recount of the votes showed his election, but the Senate seated his opponent because a judge of election had not retained the ballots in his possession until turned over to their proper custodian, the clerk to the Circuit Court. Dr. Lynch was an excellent physician. He was a brother to the late Dr. Stephen Lynch, of Baltimore. Dr. Lynch married a Miss Hopper, of Baltimore county, who, with two sons, survive him. His remains were buried Sunday in Poplar Hill Churchyard. A great number of people attended the funeral.

Dr. Sophia Jex-Blake, Dean of the Edinburgh School of Medicine for Women, says that the struggle for the medical education of women that began in Edinburgh in 1869, and has lasted almost a quarter of a century, has just ended in a victory all along the line. For seven years medical education has been provided for women in the Edinburgh school, and clinical instruction in Leith Hospital, and the lectures of the conjoint Scottish Colleges of Physicians and Surgeons have also been open to women, but hitherto the medical degrees of a university have been denied them. So far as Edinburgh Uni-

versity is concerned this exclusion still holds, but the University of St. Andrews has thrown open its gates, and now with pride Dr. Jex-Blake says "our students are entitled to matriculate as its under-graduates and to present themselves for its medical degrees." Those who have studied elsewhere can qualify for St. Andrews by two years spent at the Edinburgh school.—*American Practitioner and News*.

Dr. William H. Stokes, for over fifty years physician to Mount Hope Retreat, died this week at his home, 619 St. Paul Street. Death was the result of measles, after an illness of two weeks. Dr. Stokes was born in Havre de Grace, Md., in 1812, graduated from Yale College in 1831, read medicine for a year in the office of Drs. Donaldson and Stewart, of Baltimore, and graduated from the Maryland University School of Medicine in 1834. He was appointed resident physician to the Maryland Hospital for the Treatment of the Insane and served one year.

In the autumn of 1835 he moved to Mobile, Ala., where he engaged in general practice until 1840. During his residence in that city it passed through two severe and malignant epidemics of yellow fever, one in 1837, the other in 1839. In the spring of 1841 Dr. Stokes visited Europe, and spent a year in professional study in the hospitals of Dublin, London and Paris. In 1842 he returned to Baltimore, and in 1845 was appointed lecturer on obstetrics and diseases of women and children in the University of Maryland. He resigned in 1846, and was appointed professor of the same branches in Washington University, of Baltimore. Beginning in

1850 he attended to his private practice and his duties as physician to Mount Hope Retreat, a private insane asylum, which position he held from 1842. Dr. Stokes retired from active practice in 1889. He married Miss Mary C. Tyler, daughter of Dr. William Bradley Tyler, of Frederick, Md.

A certain professor Sauvez claims that, since the augmentation of the mass of blood during pregnancy is known to produce certain influence on the jaws, that similar conditions existing during menstruation, women are more liable to dental troubles at that period.

On general consideration it would seem to follow that menstrual outflow, disturbing the nervous system and manifesting itself in congestion toward the head and the organs of the chest, would naturally produce a state of least resistance in any tooth susceptible to pulpitis or periostitis.

After observing a large number of cases, the professor sums up his experience as follows:

"In her menstrual period woman is subject to affections of the teeth, the same as during pregnancy, which are principally caused by the congestion of the pulp or the periosteum."

"Generally, woman may be said to be disposed to diseases of the teeth when her uterus is troubled."

"The difficulties mentioned occur at the *commencement* of the menstrual period."

The paper concludes with the advice that special care be exercised by practitioners, and that obturation of caries in the fourth degree, for instance, shall not be attempted during the menstrual period.—*Items of Interest*.



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## Original Articles.

### SEXUAL EXCESSES IN THE NERVOUS AND INSANE.\*

BY CHARLES G. HILL, M. D.,  
Professor of Nervous and Mental Diseases,  
Baltimore Medical College.

It is generally conceded that the influence of sex is the most potent of all elements in the individual life. From infancy to age it is the ground-work of every action, the source of every impulse; and its modifying and controlling influence is manifested in all that is good and useful and noble in life. The distinction of sex commences with the beginning of life, for boys and girls are never physically alike. We are told by those who have taken pains to study the

subject that boys at birth average about one pound more than the girls; their stature is 4-10 of an inch greater and their pulse is a few beats in the minute faster. This difference ever widens with their growth and development. The girl preserves the delicate skin, the fragile bones, the rounded outline and the abundance of fatty tissue, so characteristic of infancy; the boy grows stronger muscles and larger bones. His collar bone becomes more curved so that he can hurl a stone better than she; his hips are narrow, while hers are broad, so that he can run faster and more gracefully. There is already a difference of taste and affections and he seeks the rude exercises which his sister shuns.

But there comes a time in early youth when this divergence receives a sudden and decided momentum. With a boy the

\*Abstract of paper read before the Baltimore Medical Association on April 24, 1893.

voice changes, the muscles become firmer, the bones stronger and a growth of hair appears on various parts of the body. This change in the girl is made manifest by the development of the breasts, the rounding of the tissues and the development of the peculiar function called menstruation. The mental changes in both sexes are not less remarkable. Unwonted desires and sensations are felt by the boy, vague longings and sudden accesses of shame-facedness intrude themselves, and he experiences a restlessness and sensitiveness to which he has hitherto been a stranger. The mental revolution in the girl is still more remarkable. The new feelings, blind longings and obscure impulses which then arise, the vague melancholy, the need of something to adore, to satisfy the undefined yearning, all attest the awakening of a new impulse, the establishment of a new era in her life. Doubt for a moment that these changes spring from the passion and development of the sexual organs and I point you to the effect of castration on either sex. Snap the tender thread that connects these organs with the complex organization of the individual and immediately all is changed. In proportion to time of life, the distinction of sex is lessened or destroyed and the character of the individual modified. If the male is unsexed before puberty the changes incident to that period are prevented. The voice retains its childish treble, the limbs their soft and rounded outlines, the neck acquires a feminine fulness and the beard does not appear. With the female just the reverse is found and there is a tendency with both to approach a mean line between the two sexes. She

grows a beard, develops a harsh voice and in her tastes and proclivities becomes masculine and unwomanly. The effect on the nervous and mental character is equally obvious. Eunuchs are proverbial for their cruel, crafty unsympathizing dispositions, and the mental and physical strength is inferior. They lack both care and tenderness and supply their place with cunning and mercilessness. Unsex the woman and you rob her of all that beautifies and ennobles her life. Castrate a man and he loses his bravery, his most worthy ambitions and all that renders him desirous of respect and esteem. With a proper estimate of the all-powerful social and physiological influence of the sexual organs and the sexual functions we are prepared to admit the potency of these organs and their functions when the seat of disease either of an organic or functional nature.

This subject is so extensive and far-reaching in its ramifications that I shall confine myself, this evening, to the consideration of sexual excess and its influence on the nervous system. I have selected this on account of the great diversity of opinion on the subject and the difficulty in reaching a definite conclusion on account of the conflicting literature of the day.

In taking the vice of masturbation as a type of sexual abuse we have the authority of one writer of eminence that the habit seldom does any permanent harm, and another, equally prominent, that it is the root of most of the evils of boyhood and that it ruins the constitution for life of every one who has ever indulged much in it. The difference of opinion in regard to effect of excessive venery, I find to be equally as decided

and irreconcilable. The frequency with which paresis has lately marked for its victims men well known by the public has emphasized this fact, for discussion of the causes of this new and dangerous disease is not by any means confined to the medical profession and I am asked frequently by non-medical men to tell them whether excessive venery does or does not cause paresis. At the present state of our knowledge on the subject I must admit that it is a most difficult problem to decide. For instance, Dr. Sheppard, after referring to other causes, says: Nevertheless I agree with Dr. Blandford in thinking that *per se* sexual excesses have more to do with its causation than anything else. In contradistinction to this Dr. Stearns in a recent work states that he regarded it the cause in 5.4 per cent. of his cases and in these it was doubtless one of many other causes; and the statistics of Dr. Mickle from the reports of the Commissioners of Lunacy in England give only 2.5 per cent.; while on the other hand syphilis was found by Dr. Folson in  $\frac{2}{3}$  of his cases and about the same by Dr. Bannister; and Dr. Archer, of the Walldorf Asylum, found that it existed in 109 out of 313 cases. The difficulties encountered in attempting to solve this question in the case of the paretic might be taken as a type of whole sexual question. The habit is essentially a secret one, whether practised as masturbation or venery, and if the latter, whether lawfully or unlawfully, or, as it has been put, whether the subject poaches upon other manors or sports too liberally on his own legitimate grounds. Men are slow to admit such shortcomings as are so easily concealed and when they become the victims of paresis it is next to impossible to gather such testimony as can

be relied on. With women the difficulties are still greater, as they guard this secret with the greatest vigilance. With syphilis, the great rival of venery as a causative factor in paresis, there are also difficulties to be encountered, but they are more easily overcome. The microscope has thrown so much light on the matter, has detected the specific taint in so many unsuspected places that on the one hand we can afford an explanation on many obscure points in pathology; and, on the other, we are alarmed at the invasion of this subtle enemy to human health and human life.

It is not my purpose to present any elaborate statistics on this subject at this time, as I have not tabulated my own cases, but to present simply some cases that have clearly come under my observation bearing on both sides of this question. (See page 116.)

#### CHLORAL IN TREATMENT OF BOILS.

M. Sphen recommends very highly, as far superior to all other treatment, the use of chloral externally in this troublesome class of affections. He directs that the boil be kept covered with a tampon of cotton-wool soaked in the following solution:

R.—Chloral hydrat. . . 5iiss,  
 Aquæ . . .  
 Glycerin aa . . . f3v.

Misce. —*Ex.*

Dr. Brown-Sequard again draws attention to the fact that occasional pruritus ani depends upon drinking coffee, and publishes a case in which leaving off the beverage completely cured a case, the malady returning on recommencing the beverage.—*Therap. Monat.*



### THE DISINFECTION OF CITY SEWERAGE BY MEANS OF LIME.

The practical employment of lime for the disinfection of sewage, as recommended by Pfuhl (*Inter. Med. Mag.*), is as follows: In order to render free from danger fresh sewage that may contain the organisms of typhoid fever or Asiatic cholera, it is necessary that lime be added to the sewerage in the proportion of at least one to one thousand. In this proportion disinfection is complete in from one hour to one hour and a half. It is necessary that during the addition of the lime the sewage be kept in motion, so that there will be a homogeneous distribution of the lime throughout it, for it has been shown by experiment that, in sewage not so stirred, lime may be added often to the extent of three to one thousand, and yet living typhoid bacilli may be detected after two hours, a condition evidently due to the restriction of the activity of the lime to and immediately about the point in the still sewage at which it was deposited. In practice it is further to be observed that the disinfectant activity of the lime is frequently interfered with through the presence of precipitating substances, such, for example, as the salts of sulphuric acid. It is also necessary that the lime should be of the best quality and freshly burned, so that in calculating the amount necessary for a given volume of sewage, only pure calcium hydrate will come into the computation.—*Boston Med. and Surg. Jour.*

### INDICATIONS FOR THE ENUCLEATION OF AN EYE.

Dr. Edward Jackson (*Philadelphia Polyclinic*, April 15, 1893) concludes an article on this subject with the following summary:

1. The presence in the eye of a malignant new growth, as glioma, sarcoma, or tuberculosis. This indication is imperative no matter how much vision the eye retains.

2. The presence in the eye of a foreign body, with iridocyclitis. If the injury be recent and the inflammatory process still active, and the patient cannot remain under observation, an eye with anything less than thoroughly useful vision should be sacrificed.

3. The presence of a foreign body in a blind eye.

4. Blindness with diminished tension of the eye-ball, following perforation either by traumatism or corneal ulcer most urgent after traumatic perforation of the exposed portion of the sclera.

5. Blindness the result of irido-chloroiditis without perforation of the eyeball, if the patient cannot remain under observation.

6. Sympathetic inflammation, provided the exciting eye does not possess vision sufficiently good to be weighed against the chances of the sympathizing eye.

7. The actual presence of sympathetic irritation; not the risk of it, unless the patient is likely to be out of reach of surgical aid.

8. Persistent pain in a blind eye, sufficient to annoy its possessor or tempt him to the use of analgesic drugs.

9. Serious disfigurement of a blind eye, even if free from pain or risk of causing sympathetic diseases.—*Western Med. Rep.*

### CONSTIPATION.

Fleiner, in the *Berliner klinische Wochenschrift*, January 16th, divides constipation into atonic and spastic. The former is due to insufficient peristalsis. It is seen in young people owing to seden-

tary occupation, and in old people as the result of the general atrophy in which the intestine shares. Dietetic measures, mild laxatives, water enemata, massage of the abdomen, gymnastic exercises, and especially faradization of the abdomen, usually suffice. Almost complete paralysis of portions of the gut or catarrh of the large intestine with mucus in the stools may be superadded. The stools are usually dry and firm, and are made up of large-sized cylindrical masses or of scybala. The abdomen is distended, symmetrically or not according to the condition of the colon. This form may also occur in children and in girls about puberty. Spastic constipation, on the other hand, occurs in the neurasthenic, the hypochondriacal, and in women with uterine disease. Parts of the intestine contract and hinder the onward movement of fæces. It occurs in lead poisoning, and sometimes even as a result of contraction of the sphincter without fissure. The stools are made up of cylindrical masses of small calibre, and small rounded masses of fæces may be present. The constant appearance of small scybala is in favor of spastic constipation.

The presence of malignant disease must be excluded by examination. Spastic constipation may be accompanied by irritable catarrh. Massage is harmful. Warm clysters, hycscyamus, and belladonna may be useful. The value of opium is well known in lead colic. Large oil enemata are most useful; 400 to 500 c. c. of warmed oil should be slowly (fifteen to twenty minutes) siphoned into the rectum, the patient being on his back with raised pelvis. The nozzle of the tube should be olive shaped. High introduction is unnecessary as long as the sphincter is intact. The

return of the enema may not occur for a few hours. A part of the oil may be absorbed in softening the fæces. If the intestine is full of fæces, the enema should be repeated on successive days. When the stool becomes bile-stained the full effect of the oil is obtained. If there are very uncomfortable sensations after the injection, defæcation can be brought about by a small water enema. If symptoms of irritation are produced, the quality of the oil should be looked to.—*Brit. Med. Jour.*

#### COLUMBIA COLLEGE GENERAL CATALOGUE.

At a meeting of the trustees of Columbia College, held on the 6th of March, the publication of a new catalogue of officers and alumni was authorized, and a committee, consisting of Professor J. Howard Van Amringe and Mr. John B. Pine, clerk of the board, was appointed to prepare the same. The new edition, which is to be issued in 1894, will be the eleventh since the foundation of the college, and will also be the most elaborate and comprehensive. The dead and living alumni of the college now number considerably more than eleven thousand. In previous catalogues all alumni have been divided into schools and arranged by classes, with an alphabetical conspectus. Only the degrees of the graduates were added to the names. It is the intention of the present committee, for the first time, to supplement the names of living alumni with their addresses and with such further information as may properly enter into a work of this description, including the professions of the men, their degrees, the colleges where they were granted, their titles, judicial, military, clerical, or po-

litical, etc. While the committee is in possession of the present addresses of a great number of the alumni, the list of graduates whose whereabouts are unknown is still appallingly long. To locate these men will be a difficult and troublesome task, which can only be accomplished by patient and persistent effort on the part of the committee, entailing a great amount of clerical work, correspondence, etc., and by the cordial co-operation of the alumni themselves. It is this co-operation which is most earnestly desired by the committee, and they appeal to every alumnus of the college, no matter of which school, to assist them with whatever pertinent information may be in his possession. It will at least be possible for every graduate of Columbia who reads this to forward to the committee his own name, class and present address, with such other facts regarding himself as he deems material. The list of the missing among the graduates in medicine is, notwithstanding the excellent catalogue of the College of Physicians and Surgeons, published in 1891, especially lengthy. Physicians holding diplomas from the medical school are most urgently requested to respond. Alumni who may be so far interested in the progress of this important undertaking as to go beyond the data concerning themselves will confer a special obligation upon the committee if they will inform them (1) of any living graduate known to be now residing or practising his profession outside of the United States, with his address and class, when known; (2) of the death of any graduate occurring within the past five or six years, date and place, when known; (3) of recent changes of address among alumni; (4) of anything else suggested by the forego-

ing description of the committee's intentions. The work, when completed, will be circulated generally among the alumni, and it is hoped that it will exert an important and sensible influence in bringing them into closer union, besides serving many useful purposes that need not be here detailed. All correspondence may be addressed to the Committee on the General Catalogue, Columbia College, New York City.

### **Society Reports.**

#### **BALTIMORE MEDICAL ASSOCIATION.**

MEETING HELD APRIL 24, 1893.

Dr. J. I. Pennington, President, in the chair.

*Dr. Charles G. Hill* delivered an address on "Sexual Excesses in the Nervous and the Insane," part of which he read, while the remainder was extemporaneous. The part furnished by Dr. Hill's manuscript is given on page 111 in this issue.

The secretary's notes on the extemporaneous portion are as follows:—

Is venery a cause or an effect of disease? All cases may be summed up under three headings, viz.: 1. Those in which sexual instinct is so strong that the inhibitory power is unequal to it; 2. Those in which sexual instinct is abridged but there is loss of inhibitory power; and 3, Those in which sexual instinct is exaggerated. Dr. Hill then reported cases of hypochondria—one was a young man twenty-two or twenty-three years old who commenced to masturbate when about fifteen years of age. His was not a neurotic case. Another was a man fifty-six years old who had masturbated during youth, married at eighteen years of age. Periods of sexual excess and



abstinence had followed each other up to the present time. The third case was a fish-monger with pains and aches innumerable. He was a hypochondriac with a history of sexual excess.

There are other cases in which these excesses are carried to an inordinate degree without any definite lesion resulting.

A blacksmith was troubled with a sensitive condition of the sexual organs. In the presence of women an emission would take place. Had cohabited with his wife excessively, also with other women. Cohabited with one woman eleven times one night. The excessive venery had continued for about twenty years.

These victims of sexual excesses are generally pale and anæmic with cold hands and feet, etc. The best patient presented the opposite features. A man was sent to Dr. Hill's institution for inordinate masturbation. Had masturbated twice the night before Dr. Hill saw him. The night before that he had cohabited with a nymphomaniac, how often he did not know. Learned the habit of masturbation at eight years of age; thirty-seven years old when Dr. Hill saw him. To cure him, smoking, chewing, and cohabitation had been tried unsuccessfully. He was a monstrosity. Penis on account of friction had become greatly enlarged and insensible with callosities upon it. A good business man. Suffered no physical incapacity whatever. Sought treatment simply to break up the habit. Bromides, camphor, low diet, and physical exercise kept the habit in abeyance but his health became impaired. Tonic treatment improved his health but restored the habit. Dr. Hill then advised hard living in the West.

Dr. Hill says that some cases have no manifest disability.

In paresis, sexual excess is one of the ætiological factors, but it is generally associated with alcoholism, syphilis, etc.

Some cases of nervous and mental troubles are wrongly attributed to sexual excess. Melancholic patients are apt to attribute their troubles to indiscretions of youth. Dr. Hill related a case of a melancholic girl who wove out a long story of secret vice and cohabitations with many boys and men. Dr. Hill thought the story to be a fabrication. He made no physical examination. Investigation proved the whole story to be false. She recovered entirely under treatment. Her trouble was temporary, brought on by study and worry about passing examinations at school. Many similar cases could be related by Dr. Hill. A girl was treated at various asylums for vicious habits; treated also by gynæcologists. She came to Dr. Hill to be treated for bad habits. Her idea of a bad habit was a filthy thought coming into her mind. She knew nothing of masturbation. Dr. Hill advised that she be taken home, all allusion to the bad habit be ignored, and the neurosis be treated by bromides, etc.

*Dr. Henry F. Hill* asked if circumcision was tried in the case in which the penis was so large. Dr. Chas. G. Hill replied that the man was a Jew. Circumcision is beneficial in young children with elongated prepuce, but not in older persons.

*Dr. J. I. Pennington* reported a case of singultus coming on after a hearty meal. Treated by another physician with pepsin. It however, continued. What caused the hiccough? All trace of the indigestion seemed to have been re-

moved. Dr. Pennington prescribed bromoform in ten drop doses every two or three hours, which cured the patient.

*Dr. S. A. Keene* reported the case of a young man of full vigor in which case singultus continued six or eight days without remissions. Different antispasmodics were tried but cannabis indica was the most beneficial. The cause of hiccough in this case was unknown. Several years afterwards a similar attack was also relieved by the same remedy.

*Dr. H. F. Hill* asked Dr. Pennington if he had tried cocaine for hiccough.

*Dr. Pennington* said, No. Several years ago Dr. Hill reported a case of singultus. Those present recommended sumbul.

*Dr. C. G. Hill* said that singultus is common in drunkards. Several years ago in an obstinate case, a dose of medicine containing capsicum afforded relief. He has tried it since not only in drunkards but also in other cases with benefit. Does not know how it acts; probably by substitution.

*Dr. E. D. Ellis* uses an aromatic mixture containing capsicum with benefit. In one case that did not give it a fair trial it failed.

*Dr. Pennington* thinks capsicum especially appropriate after a debauch or in debilitated subjects.

EUGENE L. CRUTCHFIELD, M. D.,  
Sec'y.

#### CONGENITAL CONSTIPATION.

In a clinical lecture (*Archives of Pædiatrics*, May) Dr. A. Jacobi says: Before closing I will add a few more remarks to what I have before said about constipation in general. I have spoken of what I call congenital constipation. The

sigmoid flexure in the newly born and in the infant is bent upon itself, not only once, but sometimes twice, or even three times. Indeed that part of the colon is so long that the sigmoid flexure is found in the right side often enough to have led surgeons to operate on the right side for artificial anus, instead of on the left. It is the great length of the colon at this end which causes the flexures, and these sometimes cause congenital constipation. The downward course of the contents is delayed; the fæces dry out and accumulate, and when passed finally they constitute hard whitish or yellowish balls. I have met with a number of cases where they had to be spooned out. I described a case twenty-five years ago in which a baby had no discharges at all, and believing there was imperforate rectum I operated. The baby died, unfortunately, and then I found that I was entirely mistaken; there was only just that condition of things which I have just described. Since that time it has been better appreciated, and is recognized as a cause of serious constipation.

This form of constipation will last until the fifth or seventh year, when the lower part of the intestine assumes the shape generally described in adults. Until then such babies ought not to be given purgatives, as a regular thing, but should receive one or two rectal injections a day.

A medical velocipede club has been formed in Paris for the purpose of bringing together medical men who use a velocipede instead of a carriage, and thus giving a moral sanction and support to their provincial colleagues. There are already a good number of members.—*Med. Rec.*



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BALTIMORE, JUNE 3, 1893.

Editorial.

THE HEALTH OFFICERS'  
EXCURSION.

The gentlemen who preside over the sanitary affairs of this great city are month by month gaining increased respect and confidence by their efforts to improve the city health.

Judging from the line of conduct pursued in regard to notification of infectious diseases, we greatly feared that the Health Office would devote its attention to microscopic germs and ignore "dirt" in its gross forms. Even a few weeks ago there were manifestations of this tendency to microscopic views of the subject in the talk about the necessity of having our city water-supply daily examined by chemists to see whether it is pure enough for use; and we thereupon entered our protest against this method of protection.

It is therefore gratifying to learn

through the daily press that our Health Officer, accompanied by Inspectors Healey and Maloney, has made a tour of inspection of the watershed of Lake Roland and the streams that supply that reservoir. It may be that this expedition was called forth by the very excellent article of Dr. Charles O'Donovan, recently published in this JOURNAL (see page 67) on the sources of our city water supply.

Nuisances were found, of course, and will be reported to the State Board of Health. Whether that august body will take the trouble to see that they are remedied will of course depend on its sense of its obligation to the public. State Boards of Health are sometimes affected with "swelled head" to such a degree that active sanitation seems beneath their notice.

At any rate we have two new motives for hopefulness in regard to the health of the city during the summer. First, that all citizens who read the newspapers now know that the Lake Roland water is unsafe for drinking; and that every precaution, such as boiling and filtering, ought to be taken before using it. Second, that our Health Officer has sufficient interest in public health to take a long walk of inspection, and to tote jugs containing water about with him. The addition of a camera for photographing of nuisances was a happy hit.

If frequent temperance excursions of this kind could be made compulsory in all health offices, the physical, mental and moral tone of their sanitary service would be greatly improved, endemic swelled head would be less severe, and dirt and decomposition would become offensive even to the city inspectors.



## THE DANGER OF DIET-CHANGE.

There is nothing like getting used to a thing; and the human body can accommodate itself to almost any abnormal condition, if the change is sufficiently gradual.

Especially is this true of the digestive organs. They rebel, of course, against unwholesome things; but after a while they submit, and do the work which at first they positively refused to do.

You cannot frighten the average citizen with stories about germs in his food and drink. He is as well used to them as a pig is to fleas. He knows that he has always digested and assimilated millions of them daily; so a few thousands more or less of the same varieties make no difference. Does not the Hindoo with impunity wash in and drink from a stagnant pool which has already received the slops and sewage of the village?

Does not Chicago use the adjacent portion of Lake Michigan as both cess-pool and drinking-fountain? Does not Baltimore get her drinking water from a lake, stagnant in summer, into which Towson and Ruxton drain? It is quite evident, therefore, that sewage, whether concentrated or dilute, is wholesome after once you get used to drinking it.

Change of diet however is very dangerous. The citizen who is accustomed to drinking water tainted with stable manure, common fecal matter, or dead animals, will be made violently ill if dysenteric or typhoid matter is suddenly added to it.

And, again, the citizen who has become accustomed to the mixture of disease-breeding matters which characterizes the city drinking water in summer, if he goes away for a time to a summer-resort where the water is pure, is liable to fatal

infection when he resumes the use of the city liquid. Thus typhoid fever is frequently observed in persons who have just returned to the city from a mountain resort.

The moral of it all is that change of diet, whether of food or drink, unless it be to a diet of unquestionable purity, should be made, especially in summer, with very great caution. The transition stage is the danger-point; and disorders of the digestive canal, or disorders, especially febrile, which might arise from unfelt digestive poisoning, should be taken in hand at once.

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## Medical Progress.

### IS EXOPHTHALMIC GOITRE A DIGESTIVE DISORDER?

In a paper recently presented by Dr. Thomson to the New York Neurological Society (*Jour. Nerv. & Ment. Dis.*), the author said: Persistent diarrhœa is a common symptom in Graves' disease. In the cases referred to above, astringents and other drugs had very little effect in checking the diarrhœa, while a change of diet at once brought about an improvement in all the symptoms. Since 1880, Dr. Thomson said, he mainly relies on the dietetic treatment in Graves' disease, with such favorable results that he now has little doubt that a specific disorder of intestinal (in distinction from gastric) digestion is the primary factor in the genesis of this affection.

While a structural lesion in the medulla which would account for the phenomena of Graves' disease is almost inconceivable without it sooner or later involving all the vital functions of that seat of life, yet particular functional derangements produced by toxic agent

of intestinal origin are just what might be expected, for nothing is more characteristic than the narrowly selective operation of functional nervous poisons, which may go on for years, as in the case of opium, affecting certain functions without producing either progressive changes in them, or extension to other functions. One fact in Graves' disease which points much more distinctly to a digestive disorder than to a structural nervous lesion is that it occurs in women about ten times as often as in men. That the digestive apparatus in women is subject to special disorders is notorious. The speaker said he has not as yet seen a severe case of Graves' disease in which diarrhœa was not, sooner or later, a pronounced symptom. As regards the diet in these cases, the amount of meat taken should be restricted, and milk, preferably in the form of matzoon, should be substituted. Medicinally, he employs the intestinal antiseptic remedies, and the tincture of strophanthus as a vaso-motor tonic.

#### MEDICO-LEGAL POINTS.

From a reprint entitled "Malpractice" kindly sent us by Clark Bell, Esq., of New York, we clip the following valuable points of law:

The reasonable and ordinary care, skill, and diligence which the law requires of physicians and surgeons are such as those in the same general line of practice, in the same general locality, ordinarily have and exercise in like cases:

A different rule has been held in Pennsylvania. In one case the court held that such skill was required "*as thoroughly educated surgeons* ordinarily employ," and a similar view was taken in

another; but the weight of authority is as first above stated.

The locality in which the physician or surgeon practices should be taken into account. One in a small town or sparsely-settled country district is not expected to exercise the care and skill of him who resides and has the opportunities afforded in a large city. He is bound to exercise the average degree of skill possessed by the profession generally in the locality in which he resides and practices.

Physicians and surgeons should, however, keep up with the latest advance in medical science, and use the latest and most improved methods and appliances, having regard to the general practice of the profession in the locality where they practice, and it is a question for the jury to decide from all the circumstances of the case whether the physician or surgeon has done his duty in that respect.

If a physician or surgeon departs from generally-approved methods of practice, and the patient suffers an injury thereby, the medical practitioner will be held liable, no matter how honest his intentions or expectations were of benefit to the patient.

Physicians and surgeons are bound to give their patients their best judgment, but they are not liable for mere error of judgment.

If the error of judgment is so great as to be incompatible with reasonable care, skill, and diligence, the physician or surgeon would be liable.

If the patient in any way contributes to the injury by his fault or neglect, he cannot recover for malpractice by the physician or surgeon:

And this doctrine holds where the

physical weakness of the patient or his natural temperament is the contributory cause of the injury.

Damages may be recovered for pain and suffering produced by the negligence or want of skill of the physician or surgeon, and also for loss of time and expense incurred on account of the improper treatment.

Authorities are cited, in the reprint, upon each of these points.

#### DR. HOAG ON TONSILLITIS.

The following extract is from a leaflet sent us by our friend, and Vienna class-mate, Dr. Junius C. Hoag, of Chicago:

The special characteristic of the follicular form is the presence of cheesy masses which fill up the follicles of the tonsil and project upon its surface. This feature of the disease may, indeed, be marked by the formation of a pellicle composed of the same material as that which fills the follicles, and which may simulate the membrane of diphtheria; but the removal of this pellicle, being easily accomplished, will generally enable one to make a correct diagnosis.

To my mind the most remarkable feature of follicular tonsillitis is the disproportion generally witnessed between the comparatively innocent appearance of the tonsil and the comparative severity of the constitutional symptoms. But a few years ago I made an observation which to me seems equally remarkable and one that possesses very important bearings. This observation contains the kernel of my present remarks, and is this: The removal of the cheesy plugs which occlude the lacunæ and follicles of the tonsils is uniformly followed by a

very marked amelioration of all the symptoms of the disease.

The material which accumulates in the lacunæ consists of masses of fibrinous lymph, mucus and epithelial cells swarming with micrococci, the commonest form being a streptococcus. My explanation of the severity of the symptoms of the disease is that a toxemia is produced; and conversely the removal of the source of the poisoning results in prompt relief to the patient.

My treatment is easily described. When I find a patient with the high fever and sore throat of follicular tonsillitis, I spend fifteen or twenty minutes in removing the exudate of the tonsils. I do this with the aid of three little instruments, viz.: a small spoon such as is used in clearing out the meatus of the ear, an ordinary silver probe wrapped with a small piece of absorbent cotton dipped in peroxide of hydrogen, and a small forceps with which to seize sticky masses not easily removable with the other instruments. My usual directions are to make frequent applications of peroxide of hydrogen to the tonsils by means of a brush, in addition to which I also direct the use of the ordinary gargles and appropriate constitutional treatment. But my main reliance is in the topical treatment as described and after a single séance with the patient I confidently expect to find a very marked improvement within a few hours and am rarely disappointed therein. This treatment is usually repeated once or twice.

I have treated many patients in this manner and have been greatly satisfied with the results obtained. Recently I have looked over as much of the literature of the subject as was conveniently



accessible and failed to find any similar treatment described. By my method I am convinced that I am enabled to shorten the duration of the disease very materially; indeed my patients get well in half the time required by former treatment. I therefore recommend this procedure to you in full confidence that you will be pleased with it.

#### TREATMENT OF PNEUMONIA.

An interesting discussion on pneumonia was recently held before the section of diseases of children of the British Medical Association (*Brit. Med. Jour.*, April 15th). Dr. Goodhart took ground on treatment as follows: As to drugs, a little acetate of ammonia to induce diaphoresis; a little opium, if necessary, in the shape of paregoric or Dover's powder to ease pain, and not to interfere with the action of the skin; a little aconite, perhaps, if the disease were very acute, or very painful; a little carbonate of ammonia as a stimulant, were all the drugs that he habitually ordered in a typical case. In the very acute cases sometimes seen in older children, a leech or two would sometimes bring great relief. The simplest methods were for the most part the most successful. After a free use of antipyretics for the reduction of the temperature in acute pneumonia as well as other diseases, he now used them very occasionally; they reduced the temperature without any amelioration of the symptoms, and without any influence on its course. They had this great disadvantage, that they knocked the temperature about to such an extent, that it was difficult to know how the disease was working out as regards the power of the patient. An

occasional dose of this or that antipyretic might be useful where there was some real occasion and promise of value.

The value or harmfulness of the local application of warmth was difficult to estimate. In a series of cases that had occurred in the practice of Dr. Frederick Taylor and in his own at the Evelina Hospital, which had been put on record by Dr. George Carpenter, which were being treated for one cause or another by the hot wet pack, in each case the temperature of the child rose rapidly in the pack—in some of the cases to a degree bordering upon hyperpyrexia. Dr. Dickinson had ventured upon the statement that in the case of renal disease much mischief had probably been done by purging and sweating indiscriminately; and as regards sweating that was true of its routine application in pneumonia. A poultice unquestionably had its uses, but it was also terribly abused in diseases of the chest. Poultices were liable to be applied, by even trained nurses, scalding hot; they were heavy, they got stiff as they grew cold, and they necessitated a good deal of disturbance of the child. Dr. Goodhart had now for years discarded them in favor of packs, either hot or cold, and a light cotton-wool jacket.

For some four years he had adopted the suggestion of Dr. D. B. Lees, and in most cases had applied an icebag to the chest. The details of eighteen of these cases had been published in the *Guy's Hospital Reports*. It was a very valuable method of treatment, and one that might safely be adopted in all but the youngest children without any undue precautions. Of eighteen cases, not, however, all in children, success might be claimed in

eight; in seven, although they did well it might be questioned whether the treatment had any real effect upon the disease; and in three others, all young children, there was a noticeable amount of collapse, subsiding, however, without harm as soon as the icebag was removed. The occasional occurrence of such a condition was not of much moment, for it could be avoided by a little watchfulness and could be prevented altogether perhaps, by excluding the youngest subjects—say, those under 2 years old—and by the administration, at any threatening, of a diffusible stimulant, alcohol or ammonia, and by the application of warmth to the feet. It had been suggested, too, by Dr. Lauder Brunton that it might be avoided by care in keeping the cold application from the region of the pericardium. Dr. Carpenter, who as house-surgeon at that time watched these cases, formed the opinion that this was indeed the case, and that care should be taken in applying the icebag to keep it well to the side and back. Dr. Goodhart, however, was not prepared to accept this explanation, for ice had been applied, and he had applied it himself, for the local treatment of pericarditis, and certainly without any ill result. Cold was not a remedy that could be applied in every case, but it was suitable for some. Both methods, no doubt, had their suitable sphere, though this remained to be determined. As to meat extracts and essences and alcohol, it was his conviction that more people were killed with these than harm was done by all the drugs in the Pharmacopœia. Who has not seen many times the “kept up” patient who had providentially refused to, or could not, take any more of anything, and whom the blessed rest had

saved? The fevered child cried for water; even milk and water it would have none of; we should be very careful how we poisoned it with meat extracts; and alcohol should be administered only as needed, by the thimbleful, well diluted.

#### WANTED—CLASSIFIED MEDICAL PERIODICALS.

In the *Western Med. Reporter*, May, Dr. Whitmire writes:

There are too few journals that confine themselves exclusively to the superior grade of productions, and too many that have within their covers innumerable articles of no literary or intellectual value, and written by men whose names are unknown by their nearest neighbors.

I do not wish to be understood to say that only the very best should be permitted to write for the edification of their brother physicians. I believe that writers of every class should have places provided for them. Let us have more journals exclusively for the pens of our best writers and most scientific men; another class of journals for the great number of able and learned, but not quite so prominent, physicians whose opinions are respected and whose productions are read with interest, appreciation and for information; then let us have a third class that is open for any and all who can write articles that the editor deems of sufficient interest to his subscribers to be granted space in the journal. Having established his standard, let no journal change except by way of progression, that some one from the lower rank may take its place. Then medical current literature will be on a par with any class of literature in existence. Every class will find plenty of readers. The reading physician who



wants to feast intellectually upon the writings of the profession's leading men knows to which journal to turn, and in so doing knows that his wants will be satisfied and that he will see nothing unworthy of his mental craving. If he desires to learn of the achievements of the workers in the field of science, he turns to the middle class. And if he wishes to see what some young *esculapius* has seen fit to inflict upon his brother physicians, he turns to the third class and reads, little dreaming that the writer of that article is probably destined some day to be the leader *par excellence* in the field of medicine and surgery.

As it is now, our journals are filled with writings of all classes. If one wishes to read a dozen first-class articles each month he is obliged to take as many journals, for we have no *strictly* first-class journals; and of all the scientific journals (in proportion to the number in each branch of science) there are more medical journals than any other kind that are scarcely worth the small sum they cost. Give us a better classification and a better standard and we will give you a better price and no less patronage.

#### LEPTOTHRIX MYCOSIS OF THROAT.

Upon this interesting subject Dr. Cheatham writes as follows in the *Amer. Pract. & News*, May 20th:

B. Frankel, of Berlin, in 1873 pointed out the presence of leptothrix threads in an affection of the tonsils, base of tongue, etc., which had before been known as follicular inflammation of these parts. Some authors have since gone so far as to say that they are one and the same disease; that they all contain the leptothrix threads. I feel assured they are

two entirely different diseases; that the presence of follicular tonsillitis makes one more liable to have mycosis of the part, as leptothrix threads are present in most of our mouths most of the time. In follicular disease of the tonsils there is more constitutional disturbance; the contents of the lacunæ are yellow and easily detached. The microscope shows the absence of leptothrix threads. The deposits are scarcely ever above the level of the tonsil surface. I have taken a syringe in a case of chronic follicular tonsillitis, passed the tip into the openings in the tonsil and washed out dozens of small lumps of secretion which have a disagreeable odor. These deposits are within the lacunæ and the tonsils are usually enlarged; the disease is curable; in many cases it responds to treatment readily. These symptoms do not hold good in all cases.

In mycosis leptothricia of the tonsils, the tonsils are usually small; usually so small you can get hold of them with a tonsillotome to remove them; there is no constitutional disturbance; no bad odor; patients complain of foreign bodies such as hair, fish-bones and splinters of tooth-picks being in their throats. The deposits are white or yellowish white; most always very difficult to detach; frequently can not be even curetted away; have to, in a majority of cases, be torn off with forceps; are elevated above the surface of the tonsils; sometimes pedunculated; often look like small spurs; are frequently located, not in the crypts, but away from them; may be on the pillars of the fauces. The microscope shows numerous leptothrix threads present. Jaksch says "these threads are long bacilli, usually segmented and arranged in large ribbon-



like bundles; they stain bluish-red in iodine-potassic-iodide solution. Shorter bacilli are sometimes present which do not stain."

Four or five years ago I had under my observation two healthy school girls, with tonsils very small, in fact no tonsils at all. Yet what remained of them was studded with hook-like deposits of leptothrix. These deposits were not only on the tonsils but over the base of the tongue, the pharynx, and the faucial pillars; the curette was used, and all kinds of applications made, with a rapid return of the deposits. Both cases were finally relieved by stopping all sweets, and giving the alimentary tract the correct attention.

March 3rd, Mrs. R. was sent to me by two Indiana physicians. She had had for several years an affection of the throat, with sensations of hair or fish-bones in the throat. Her family being tuberculous, her friends and physicians were much alarmed concerning her. She presented a most typical leptothrix mycosis of pharynx, faucial pillars, tonsils, and base of tongue. Those on the base of the tongue were flatter and larger than those on the other parts. Plate xxxvi in Dr. Robert Krieg's Atlas of Diseases of the Throat, etc., gives a splendid picture of the disease as seen in Mrs. R.'s case. I had considerable difficulty in getting enough of the deposit off (as it was so adherent) for a mount for the microscope. The microscope showed the threads of the leptothrix to be very plentiful. Mrs. R.'s throat at times gives her no trouble, as the disease occasionally gets well of itself, to return again in weeks, months, or years.

Leptothrix mycosis of the throat is very difficult to cure. The teeth should be

investigated, for there you may find a nidus for the parasite. This is said to assist in the production of tartar and decay of the teeth. The deposits should be removed, if possible, by forceps or the curette, or, still better, a gallano-cautery point should be inserted into each deposit, applying it to several each day, and making the applications not too close together. This treatment is slow, painful, and tedious. Cocaine will of course prevent the pain. This treatment gives the best results.

Again, all foods (such as sweets) which are liable to ferment in the alimentary canal should be stopped, and the canal kept as aseptic as possible. Sometimes the disease disappears, as I stated before, without treatment; again, no treatment does any good; then again, calomel internally with the alkalies and salol and naphthaline may make a cure; but it is well in a genuine case of mycosis leptothrix pharyngea not to make any promises of permanent relief. Cases may hang on for years, and pass from physician to physician, yet get no benefit.

#### TINCTURE OF IRON FOR BURNS.

At the earliest possibility after the occurrence, apply the tincture of iron over the surface of the burn with a feather or soft brush, so as to moisten it everywhere. Where the cuticle is not destroyed and removed it should be used full strength; if the cuticle is gone and the surface raw, dilute with water one-half or two-thirds. How prompt the relief from pain is after the application no one can tell save one who has tried it. In scalds and superficial burns the immediate application will not only allay the pain but prevent blistering. There

is a characteristic feature connected with burns that deserves consideration, and that is the tendency to too much and too long continued suppuration—to become chronic and to continue indefinitely. Old sores from burns have usually been hard to cure. For the relief of this kind of traumatism the proper course to pursue is to prepare and use a salve in the following way: Take of vaseline or lard one ounce, of tincture of iron one drachm, more or less, combine the two by rubbing together either in a mortar or in a plate or saucer with a knife or spatula. Spread this salve thinly upon a soft cloth and apply to the entire raw surface; this will soon diminish the flow from the raw surface and cause it to heal rapidly.—E. F. Starr, *Atlanta M. & S. Journal*.

#### ENURESIS DIURNA.

In the *Amer. Pract. and News*, May 20, Dr. Simpson says, in part: I have in the past four years come in contact with quite a number of cases of day-wetting, and one or two I have failed to treat with as much satisfaction as I would like. I have tried any number of drugs, and failed. A child who is not relieved by the ordinary drugs has a cause for his incontinence that is worse than the incontinence, and that is masturbation; and you will find when you treat him for masturbation that he gets well. You must keep a close watch on him, for he is so sly, and will repeat the act as soon as the blisters heal. You must have complete control over your patient or you do him no good. If you make close inquiry of the mother, you will find that she frequently catches the child rubbing the parts, and this results in an erection, and immediately

you find the little fellow has made water. He is unconscious of the desire until he finds that his water is trickling down his leg and his clothes are wet. You find that the majority of these patients play with the parts. The question of masturbation is becoming quite a serious one for the physician to cope with and experience brings this question up quite often during the year.

The constant irritation of the parts by self-abuse leads to chronic inflammation of the whole prostatic portion of the urethra and the neck of the bladder, which is very sensitive.

My experience with these cases is that I find this condition to occur in children from five to eight years of age. I speak only of that class that are free from the trouble at night, and suffer during their waking hours. I have found tight prepuces in two cases, and they were circumcised with relief, so long as the wound did not heal, and as the parts were well, why they would return to their old habits. In both cases I blistered along the dorsum of the penis and down on the perineum. I found, as long as I kept the blister from healing, that they did not suffer from the incontinence and for some time afterward before they had any return, and then they began their old habits of playing with the parts and the incontinence returned with the same regularity as before the blistering. I had to repeat the blisters on one three and the other four times before I controlled the trouble, and as it is now four months since either one has suffered from any trouble of that character. I do not question in either of these cases but the cause of the incontinence was masturbation. And I



based my belief upon the fact that the mothers of both of these boys would catch them playing with the parts, and almost immediately following they wet their clothes, and one mother told me that she found the little fellow frequently with an erection when she caught him playing with the parts. You find that these children are exceedingly nervous little fellows. They have loss of appetite, seem to be debilitated, and show some mental hebetude.

In regard to treatment, will say that I have gone all the way down the list, and find in these intractable cases that you can not do any thing for them, except the frequent blistering, and it must be persisted in until you give them relief. I have the first case in which to see it fail, while circumcision, atropia, rhus aromaticas, and all the drugs that are said to do good, in a great number of these cases, fail signally in giving more than temporary relief.

#### WOUNDS OF THE EYE BALL.

From an elaborate article by Dr. N. C. Steele in the *Ophthalmic Record*, May, we clip the following:

The general principles as to the treatment of wounds in other parts of the body hold good here. First, scrupulous removal of all foreign material practicable. Second, rest. The first rule includes washing the wound and the whole eye ball and its appendages with appropriate antiseptics, as an aqueous solution of bichloride of mercury 1 to 3,000 or 4,000. Every physician should be thoroughly impressed with the importance of this procedure. Continue the antiseptic wash as long as there remains solution of continuity.

Antiseptic compress and bandage is

called for by the second rule, that of rest. Cold applications will be proper for 48 or 72 hours. After that warm or hot ones will as a rule do more good.

In wounds of the cornea which do not penetrate to the anterior chamber, a simple antiseptic wash occasionally used, with or without a bandage, is usually sufficient. Cocaine or atropia or both may be used if there be much pain either at first or later. A clean-cut corneal wound, even entirely through the cornea, generally heals promptly under an antiseptic dressing. If the aqueous humor escape it will usually be renewed in 48 to 72 hours. The chief danger in such wounds is entanglement of the iris in the wound.

#### "PRESSURE POUCH" OF ŒSOPHAGUS.

At a recent session of the Royal Medical and Chirurgical Society (*Brit. Med. Jour.*) Mr. Butlin read a paper on a case of "pressure diverticulum or pouch" of the œsophagus, typical in its situation and in the symptoms which it occasioned. It was removed through a long incision on the anterior border of the left sternomastoid muscle. The omo-hyoid muscle and the superior thyroid artery were divided; the carotid sheath and its contents were drawn aside. The pouch was easily found and separated from the surrounding tissues. As the pouch was cut away, the opening into the gullet was closed with fine silk sutures. The patient made a rapid and excellent recovery. The author believed this to be the first operation of the kind performed in England. The only similar case with which he was acquainted was that described by Professor von Bergmann in *Langenbeck's Archiv*, Band xliii, Heft 1, 1892. The question of the origin of



pressure pouches was shortly discussed and the great difference in the characters of some of the pouches pointed out. The operation was not difficult; indeed, it was much easier than had been expected. Justification for the operation was found in the intractability of the condition to every other kind of treatment, in the misery occasioned by the pouch, and in the fact that, in more than half the recorded cases, death had resulted from the disease, generally by slow starvation.

The pressure pouches sprang from the junction of the pharynx and œsophagus, and most usually were directed backwards. Kocher, of Berne, had recently operated on two cases of this kind, in each with a successful result. The symptoms of the affection were quite distinct, yet nevertheless some of them had been mistaken for stricture.

#### HIP AND SPINE DISEASES.

In stating his personal recollections of Dr. Dudley, the great surgeon of Kentucky a generation past, Dr. Bedford Brown records (*Gaillard's Med. Jour.*, May), among many other peculiar therapeutic methods, the following:

In the treatment of spinal curvatures and hip-joint diseases, Dudley discarded the use of all mechanical apparatus in toto, as being cumbersome and useless. He believed that the very beginning, the fountain head of these affections, was located in imperfect digestion and mal-assimilation, and the imperfect formation of blood, and that the system failed to receive the nutriment necessary to sustain its reparative processes against local injuries; and furthermore that if the blood was properly renovated and all

mechanical pressure removed, the system would right itself and the local disease disappear. The patient was placed and maintained in absolute recumbency on a firm mattress during the entire treatment and not permitted to assume the erect posture, but allowed to roll over his bed at will, and was amused in every possible way. The state of the digestive organs and general health received constant attention. The diet consisted of fresh meat once a day, skimmed milk, brown bread and corn meal gruel three times a day. Under this regimen the digestion of these little patients would be restored, the appetite would become sharp, the secretions active, the complexion would lose its pallor and become rosy, the mind cheerful and the local affection steadily progress toward restoration. Another feature of his treatment of these cases was daily massage practised over the entire body and limbs by means of towels saturated in salt water and dried. This practice gave a stimulus to the circulatory system that invigorated the general nutrition in a surprising degree. I visited daily five cases—two of hip-joint disease, three of spinal curvature—in children treated by him in this manner, and all made permanent recoveries. As mentioned in a previous page, Dr. Dudley believed that a great majority of local affections are the result of constitutional causes.

#### EPILEPSY.

In a paper presented to one of the medical societies, Dr. Baker (*British Medical Journal*) said that loss of consciousness, and not convulsions, was the true pathognomonic sign of epilepsy. From a study of the cases of epilepsy in Broadmoor Criminal Lunatic Asylum he

showed that traumatic causes, especially head injuries, might induce a dangerous form of epilepsy, that idiopathic causes originated a type less violent in character, and that epileptics with congenital defect were not regarded as so homicidally inclined as those whose neurosis was due to other causes. He discussed the influence of aortic valvular malformation in the production of the disease in certain cases, and gave details of the case of a female patient in whom true cardiac affection had evidently brought about instability of the higher regions of the cerebral cortex through deficient nutrition.

#### ASPHYXIA NEONATORUM.

For this accident Dr. Nunn, in the *Southern Medical Record*, May, recommended the following:

The infant being laid upon a table or any other suitable support, the operator stands or sits at either side which happens to be most convenient; he slips the hand which is toward the head of the child palm upward under the back, so as to grasp the ribs and be ready to assist in compressing the chest, and expelling the air; this hand also raises the chest, and permits the head, supported by the edge of the index finger, to fall back the distance desired to make extension and raise the epiglottis. The operator next grasps the legs of the infant with his other hand, back upward near the ankles; the index finger inserted between the legs serves to give a better grip.

Now by steadying the body with one hand, and with the other raising and bending the legs upon themselves, and pressing the thighs upon the abdomen, the diaphragm will be pressed up into

the chest and the air expelled therefrom. This operation may be assisted by making pressure upon the ribs with the fingers of the hand supporting the back. Upon making contrary movement the air again enters the chest. So far, of course, there is no change from Byrd's method, the only difference being, that whereas in Byrd's method the upper and lower extremities of the body each swings through an arc of say forty degrees, in this ~~one~~ the lower extremities alone move, and pass through an arc equal to the sum of Byrd's two arcs. Thus it will be observed that in mechanical equivalents both plans are the same.

What advantages then the change?

It enables us to call in the aid of the hot bath, while continuing the artificial respiration, and all without additional help; all that is necessary is to have a tub of suitable length, so that extension can be made; have water of the desired temperature in sufficient quantity to cover the chest of the child, but not the mouth and nose, and then proceed with the manipulation as already described.

This plan of resuscitation has been used by several physicians in Savannah for years and with good results.

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#### Medical Items.

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In England proprietary medicines containing poisons must according to law be labelled "poison," and can be sold only by chemists.

Urethostomy is the term applied by M. Poncet, of Lyons, to the operation of perineal section with permanent fixation of the membranous urethra into the peri-



neum, done in cases of severe and otherwise irremediable strictures.

Duke Karl Theodor, of the Royal House of Bavaria, completed on Friday, the 7th of April, in the presence of six colleagues, his two-thousandth successful operation for cataract. The operation was performed in his laboratory at Munich, an institution fitted up and maintained by his Highness for the study and cure of diseases of the eye.

A paste of ground mustard and water is a first-rate agent for removing traces of disagreeable smelling substances from the hands, such as salts of valerianic acid, cod liver oil, etc. Huber claims that any oily seeds when powdered will answer this purpose. The smell of carbolic acid may be removed by rubbing with dampened flax seed meal.—*Reg. Pharm.—Albany Med. Annals.*

The fourth annual session of the Association of American Medical Colleges will be held at the Pfister Hotel, Milwaukee, Wis., on Wednesday, June 7, at 3 P. M. Amendments to the by-laws will be suggested, granting associate membership of one delegate from each recognized school of Post-graduate Instruction in the United States, and from each State Board of Medical Examiners in the United States. It is also proposed to divide membership in the association into three classes, of active, associate, and honorary.

Five medical practitioners, we are told, accepted office as judges in a "Grand National Baby Show" recently held in Melbourne, and for three days exercised the novel responsibilities of their exalted station. The appointment

was not honorary, but by a curious oversight the judicial salary does not seem to have been fixed beforehand. The effect of this omission was somewhat dramatic. At the close of the exhibition each member of the medical bench sent in a bill for £5 on account of his professional services. The director could not meet even this moderate demand. The umpires, not to be beaten, struck work to a man and withheld their decision.—*Ex.*

It will interest our subscribers to know that Messrs. Scott and Bowne, well-known manufacturers of Scott's Emulsion of Cod Liver Oil, whose headquarters were formerly at 132 and 134 S. Fifth Avenue, have removed to the Scott and Bowne Building, which is located on New Chambers, Pearl and Rose Sts., New York City. Their new building is twelve stories high, it is splendidly equipped, and is considered to be the best of its kind in the city. Messrs. Scott and Bowne are profuse in their thanks to the medical profession for the appreciation shown for Scott's Emulsion, and while they maintain that their success would not have been possible unless their preparation possessed superior merit, they loudly proclaim that it was in a great measure due to their extensive advertising in medical journals.

An exchange announces that the medical degrees at present open to women in Great Britain are those of the Universities of London, Ireland, Glasgow, and St. Andrews; the conjoint Colleges of Edinburgh and Glasgow, and of Dublin; and the Society of Apothecaries, London. There are separate medical schools for



women in London, Edinburgh and Glasgow. The London school contains 144 students, and is located at 30 Handel Street, Brunswick Square, W. C. Women are also admitted to the men's medical schools at Dublin, Cork, Belfast and Newcastle-upon-Tyne. Detailed information about the various schools appeared in the March number of the *Fortnightly Review*, in an article by Mrs. Garrett Anderson, M. D. It is believed however, that the fees charged at the London school have been reduced since Mrs. Anderson's article was published.

We observe with pleasure that the excellent work on "Hygiene of the Sick-Room," by our friend, Dr. William B. Canfield, formerly editor of this JOURNAL, has met with very favorable notice in Great Britain. Higher praise could hardly be given than that accorded to Dr. Canfield's work in the review columns of the *Brit. Med. Jour.*, of May 13. Noticing that the book is the outcome of a series of lectures delivered in the University of Maryland Training School for Nurses, the reviewer says "If all lectures to nurses in America are as good as these, we can only congratulate the American nurse on her advantages;" and again, "On ventilation and heating the author writes with his wonted clearness and good sense." "There are good chapters on infection and disinfection, and on the principal diseases due to septic organisms." "The book is worthy of hearty recommendation."

P. Blakiston, Son & Co., are the publishers.

The following humorous items are given in a recent report of the examina-

tions held in the Sanitary Institute of Great Britain. One of the candidates, when asked what a death-rate was, replied that it was a rate levied on the living to support cemeteries.

In reply to a question about the wilful exposure of a person suffering from an infectious disease: "He must not," said the examinee, "ride in any conveyance except a hearse without first informing the driver." Another reply to the same question laid it down as imperative that "a person dying of an infectious disease must give notice to the local authority within twenty-four hours." A candidate who evidently thought drastic remedies should be applied in cases of infectious diseases, remarked that "members of a family where small-pox had broken out must be sent to a hospital and well boiled!" another mildly remarked that "among the precautions against small-pox vaccination might be looked for;" and another, with cautious liberality, advocated as precaution in the same connection that "the patient should be given an old rag for his own use." In answer to some physiological questions, one examinee asserted that nitrogenous foods build up the "waist" of the body; and that "milk is the best food for children because it does not require any chewing." Another candidate gave the following elaborate and curious reply to some questions with regard to clothing: "In hot countries the perspiration which is in the skin is evaporated into steam, which goes up to form cloud and comes down in the form of rain." Sometimes the answers are most illogically "mixed," as in the case of one which stated that many articles of food have to be adulterated in order to keep them pure.

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#### ADDRESS

DELIVERED BEFORE THE ALUMNI  
ASSOCIATION OF THE COLLEGE  
OF PHYSICIANS AND SUR-  
GEONS, BALTIMORE,  
APRIL 18, 1893.

BY THOMAS H. BRAYSHAW, M. D.,  
OF GLEN BURNIE, MD.,  
A member of the class of '85.

Mr. President, Gentlemen of the Faculty, and Brother Alumni of the College of Physicians and Surgeons, I give you greeting to-night—a glad greeting, mingled with truest elation of soul, and thanksgiving that we again assemble in this hall to ignite once more, on the altar of our *alma mater*, the sacred fire of friendship and fraternity, engendered by the magic tie of fellow-

ship, which the annual sacrificial rites of laughter and language, of song and story, offered up to the great gods and the lesser, governing the economy of our college, weld yearly into a stronger bond.

Gathering as we do from near and far, from the frozen north, the sunny south, the wild and woolly west, the conservative east, yea, even from countries beyond the broad Atlantic, as we stand "face to face, and hand to hand in greeting," the past, with all its hidden freight of joy or pain, vanishes. This is an epochal moment. We know, *pro tempore*, neither past nor future. The present entirely suffices us. It is enough to know that the divergent lives that make up the sum total of our association, which 363 days of each year are as widely sundered as individual natures

can be, on to-day and to-morrow, focusing, send convergent beams of spirit, if not of actual personality, to this the Mecca of our yearly pilgrimage. The welcoming speech and cordial hand-clasp consummated, the present slips away.

Now comes, to the least imaginative, a sort of Alexander's feast. Filled with the wine of fancy (often as sure an intoxicant as the choicest vintage of Bacchus), we fight our battles over again. The grey-beards become young under the contagion of youth and mirth; and those in the flower of maturity, too, renew the care-free mood and manner, which well becomes the newly fledged M. D. It does honor to our manhood, this abnegation and effacement of the purely practical, and unpleasantly prosaic. Renewal of adolescent fervor and feeling is a dispensation direct from Heaven; a nectared chalice we too seldom sip. Then let us enjoy it while we may, and sing with Cowper, "Oh, the joys that came down showerlike, ere I was old."

Has it ever occurred to you that there is a sharp dividing line between youth and manhood? Suddenly startled by the unveiling future, we look back, and start with dismay when we see the past, which we thought so near, vanishing in the dim distance, shapeless, confused, and estranged from our present. Then we know that we are able to assume the *toga virilis*, and recognize with something like a sigh, perhaps, that we have put away childish things. And only do we really revive the fun and jollity of those halcyon days, when, as now, we meet in genial conclave to render homage to the benign mother, whose ma-

ternity is as exhaustless as is the fraternal feeling we have drawn from her teeming bosom. The kinship thus begotten unites the unworthiest on the muster roll to the worthiest. The peccadillo of one reflects on the entire family. Let us see to it, then, that we besmirk not her name or fame by unmanly deed or unprofessional discourtesy.

For what a grand, a good, a glorious profession is this to which we have consecrated ourselves. The refined and cultivated physician has been an object of deepest interest in every enlightened age and country, and as the world swings tirelessly on its journey through the trackless realms of space, this interest decreases not.

In ancient Greece and Rome, those great centres of Old World civilization, the physician was held in the highest esteem and veneration. The praises of the surgeon, too, have been heralded throughout the universe. There has been no important military enterprise since the first glorious battle for freedom was fought, wherein he is not a leading figure; while the influence he is capable of exercising over the rank and file of uniformed hosts potently proclaims the innate power of a soul that dedicates itself to repairing the ravages of hideous war. Of this the examples of Ambrose Paré and Baron Larrey are striking illustrations. When the Father of French Surgery appeared at Metz, then invested by the troops of Charles V, the soldiers, exhausted by hunger and fatigue as they were, crowded about the great surgeon, exclaiming with child-like faith and simplicity, "We have no longer any fear of dying, even if wounded. Paré, our



friend, is with us." The great Napoleon, who weighed well the virtues and vices of others, if not his own, declared that Larrey, who followed him through all his campaigns, was the most upright and honest man he had ever known.

And many a mutilated survivor of ruthless carnage in this land has reason to bless the nameless heroes who, regardless of shot and shell, and actuated by the tenderest humanity, braved the battle's brunt to succor the victims of bullet and bayonet. I say nameless, because heroism was so common a virtue among the surgeons of our late war that it became too herculean a task to register each name, and the great mass of well-doers have sunk into oblivion; Drs. William Hammond and S. Weir Mitchell, symbolizing, perchance, the "survival of the fittest," since they are oftenest quoted. Heroism is not less an attribute of the physician, and if not so boldly recognized by the public, is quite as glorious a principle in one as the other. Who of us that has spent even a short lustrum in service has not had a hand-to-hand encounter with the grim spectre that sentinel every path? Not a month ago I passed through such a struggle. My patient was a genial, wholesouled gentleman, a *bon vivant* and free imbibor of choicest tippie, wealthy, kindly, freehanded to all sorts and conditions of men. He was more than a decade my senior, yet he loved me—I say it with all humility—and placed his life in my hands, and I struggled ardently for it. I left him neither night nor day; I watched him as tenderly, as carefully, as closely, as mother does her first-born son; I had the best nurses; I had four excellent physicians in consul-

tation; but on the fifth morning Atropos moved the fatal shears, and the cord of life was severed.

Such a foray as this, which vanquished my confreres and myself, nullifying the great mystery of life by confronting us with the greater mystery of death, either ennobles or embrutes a man. Let us strive after the badge of knighthood rather than the brand of callous stoicism which the vast majority seek to blazon on their brows.

Strive also to implant in the hearts of your patients a belief in your capability to keep disease at bay, that your courage is as impregnable as your patience is expansive, and the victory is gained over half the ills to which flesh is heir—for the faith-cure, my friends, is no chimera—unless indeed the Book of Life of individual entity, as in the case just cited, is filled to its final margin; then, alas! human skill and courage avail nothing. *Hic finis faudi.*

The history of medicine is a theme too vast to be fitly broached in so trifling an oration as mine, yet it is meet to say something of the progress made in this fast waning century, by physicians and surgeons in America. I will, however, be brief and not in any degree statistical. The bare bones of statistics offensively rattled in your tired ears would win, I fancy, as little enthusiasm as if I forced upon you a didactic recital of the wrongs of the dusky-eyed Princess Kiaulani, who, since she is a woman—and beautiful—we will hope may one day wield the sceptre of the tiny island kingdom she claims her home.

When Boerhaave, the most accomplished physician of the 18th century,

died, he left behind him an elegant volume, the title page of which declared that it contained all the secrets of medicine. On opening the book to search for the treasure, every page was found blank, save one. On that was written, "Keep the head cool, the feet warm, and the bowels open."

Edward Clark declares the result of therapeutical experience from Hippocrates to Boerhaave was fairly summed up by the latter in these eleven words. Wise practitioners were content to restrain their *materia medica* within this modest limit. The great majority, however, bled and dosed by the book, or adopted some strange theory of planetary influence, signatures, animal spirits or occult force, and treated disease in accordance with whatever theory they chanced to believe in. A hundred years ago medical practice, as a rule, deserved and gained the ridicule of Molière and the satire of Montaigne.

But the lapsing years have manumitted medicine from its slavery to superstition, bold empiricism, quasi-charlatanism and speculation, developing it into a symmetrical science. The magnificent advances which have been made are due to the subordination of facts to physical investigation and demonstration, the prodigious strides in pathological anatomy during the intervals between Morgagni and Virchow being founded solely on the microscope and its unrestricted use.

It has not been a century since witty, but narrow-minded, Sidney Smith, who was no Epimetheus, criticising our nation, said: "In the four quarters of the globe, who reads an American book, or goes to an American play, or looks upon an

American picture or statue? What does the world yet owe to American physicians and surgeons? What new substances have their chemists discovered? What old ones have they analyzed?" and so on, *ad nauseam*. The times truly have changed; America takes the lead in many things: in titled husband hunting, in book making, in aggregating limitless wealth, scientific research, in exploration of the earth's hidden places; and we can point with honest pride to the services American physicians have rendered to the world. The intimate connection of the Old World with the new, in thought and deed, has produced some curious coincidental discoveries, showing conclusively that genius, in spite of environment and separation, is constantly aiming at, and sometimes grapples the immensities in concert. This is proven by the fact that the same year, 1796, in which Dr. Jenner vaccinated his first patient, Dr. Waterhouse undertook a similar performance in Cambridge, Mass.; and Dr. James Jackson in the neighboring city of Boston.

The United States Dispensary informs us that chloroform was discovered by Mr. Samuel Guthrie, of Sackett's Harbor, New York, in 1830. Almost simultaneously the same important feat was announced as accomplished by Loubéiran, in France, and Liebig, in Germany. Yet to our country belongs the primal triumph. You have all doubtless heard the story of the American, who a decade or so ago, while travelling in Hungary, attended a public meeting in one of the leading cities. One of the speakers in the course of his oration alluded to Boston in the United States. He referred to it as a place well known



to his hearers, and distinguished, not as the cradle of the American revolution, not for its commerce, not for its literature, not for its statesmen, its authors, its poets, its theologians, but as the spot where sulphuric ether as an anæsthetic was discovered. This priceless boon to tortured humanity, God-given, we have need to bless our day and generation for.

The pioneer operation for coccydynia, excision of the coccyx, was performed by our fellow-countryman, Dr. Josiah C. Nott, of Mobile, Alabama, in 1832, although to Sir James G. Simpson, of the Royal College of Surgeons, England, is often erroneously awarded the credit. To America also belongs the honor of extirpating the superior maxillary. Small portions of it had been chipped off even in the 17th century, but the first grand and difficult operation was successfully made in this city of Baltimore by Dr. Horatio G. Jameson, in 1820, who took away nearly the entire bone on one side, the roof of the antrum alone being left. But the distinction of performing the bolder and most formidable operation of disarticulating the jaw-bone belongs to Valentine Mott, who accomplished it in 1821. Staphylorrhaphy, first methodized by *Roux*, of Paris, in 1819, was performed the following year by Dr. John C. Warren, of Boston, without any knowledge that palate suture had been attempted in Europe, an assertion which can readily be believed, when it is recalled that the intercourse between the countries was necessarily infrequent.

It has generally been conceded that Sir William Ferguson was the first to call attention to the importance of dividing the muscles in the arches of the palate, as a means of facilitating the reunion of

the edges of the fissure, but it is a well authenticated fact that this high credit belongs to Dr. J. Mason Warren, whose modest paper announcing the consummation of this daring operation antedates a similar paper from the pen of the British surgeon, by at least eighteen months.

It was during the first years of the 19th century that the greatest of all contributions which the United States has had the good fortune to make to gynæcology came forth from the then far West. This was the initial performance of ovariectomy by Ephraim McDowell, of Kentucky, who successfully operated in 1809, again in 1813, and again in 1816, although he did not publish these cases until 1817. What a commentary upon the grand nature of the man was this calm deliberation and hesitancy to rush into print. He had performed an operation never before attempted in the history of the world, for in Germany ovariectomy was not performed until 1819, in England not until 1836, and in France it was as recent as 1844.

And now a word regarding the medical literature and institutions of Baltimore during this century. There have been but few publications between covers. Drs. N. R. Smith, Goddard and Neill, each in his day issued a monograph on the "Surgical Anatomy of the Arteries." But among the few original works in this department I must mention those of Dr. John D. Godman, a native of my own city of Annapolis, and the most prolific writer of his time, whose "Anatomical Investigations, comprising Descriptions of the Various Fasciæ of the Human Body," published in 1824,



and his "Contributions to Physiological and Pathological Anatomy" in 1825, are pronounced really original and valuable productions, by those who have read them. Dr. Charles Frick, of this city, is also placed on record as a careful, conscientious reporter of original observations, with the least possible amount of theory, and with direct reference to practice.

Baltimore had also the honor to produce the third journal published in the United States in the interest of our profession, which under the title of the "Baltimore Medical and Physical Recorder," was edited by Dr. Tobias Watkins, in 1808-9. This periodical only reached No. 1 of volume second. It was the progenitor of many such, doomed before parturition to an untimely end, but this niche is now admirably filled. The C. P. and S. has among her alumni many surpassingly clever wielders of the pen as well as the scalpel, numerous valuable contributions in pamphlet form, articles which first saw light in medical brief or journal, testifying alike to the mental acumen of her sons, and the benefits to be derived from a well-edited monthly.

It is not without interest to us to know that the Medical and Chirurgical Faculty of Maryland was organized in 1789, the second organization of its kind in this country, the Massachusetts Medical Society being only eight years older.

Think of the fraternal relations that have existed between the members of our profession for a hundred years and more, and resolve that the feeling of brotherhood and *esprit de corps* shall not languish as long as you and I shall

live. Our own school the ignorant datist is wont to speak of as a new institution, but when we reflect that Washington University graduated her first class in 1828, and the College of Physicians and Surgeons, hale and vigorous daughter of this hearty, honored mother, this year attains her majority, we cannot cease to congratulate ourselves that her patent is of no recent issue, and that we can claim all the prestige accruing from lengthy lineage. As the long roll of graduates increases year by year, keeping in touch with our *alma mater*, the aureole of fame that must encircle the brows of the yet undiscovered Virchow, Koch, Charcot or Pasteur, who acquired wisdom at this hive of learning, will surely reflect a lesser glory on us perhaps more industrious and happier, but less famous creatures; for fame is not a sure harbinger of enduring bliss. "Every seminary of learning," says Sir Joshua Reynolds in one of his academic discourses, "is surrounded by an atmosphere of floating knowledge where every mind may imbibe somewhat congenial to its own original conceptions." Some man towering in intellect above his fellows, ordained by Nature to lead in unexplored regions, and to dominate new fields of thought, has here and there made his appearance, and marked his epoch as an era. In modern times philosophy has felt the influence of Bacon, theology that of Luther, science that of Newton, and politics that of Napoleon; surgery, medicine, chemistry, anatomy, physiology, and the collateral science of botany, each in turn has felt the propulsive influence of Parè, Boerhaave, Berzelius, Morgagni, Harvey and Linnaeus. Who can predict which is the

chosen vessel in this assemblage? Yet he may be here.

The fallibility of human dicta we are warned against; yet cling my brothers to the creeds of C. P. and S. Remember these pithy words of Robert Browning.

"The column holds the cornice up."

With such a stalwart column to support her, can she fall back? I trow not.

In the field of labor the graduates of medicine and surgery map out for themselves; there are but two roads to usefulness and renown open. The one is that taken by the specialist, the other the meandering way of the general practitioner. And viewing the chances of aggregating the "almighty dollar," from my individual outlook, I advise the great majority to take the latter thoroughfare. I grant that the specialist is a necessity, that there is exquisite pleasure in burrowing down to the primordial germ of an insidious and baffling disease, and tunnelling back to health, *via* a nepenthe self-originated, be that nepenthe some as yet unknown quantity in *materia medica* or some instrument of a surgeon's invention. But it is not granted to all to originate. At best we can but heal. And to do that wisely and well, brethren, is the grandest boon in the bestowal of the Omnipotent Ruler of the little worlds in which we severally have our orbits. Success does not come unsought. The tactless M. D. sits down in his office, and awaits the coming of the call which halts on the way, and mayhaps falls into the hands of a rival practitioner. The tactful man exhibits himself, emulates Chesterfield in his urbanity alike to rich and poor, is suitably solicitous regarding crops—for I am now speaking of that important factor in the

healing art, the country doctor, who apart from being a general practitioner of medicine, must also be a skillful generalizer of ethics and isms—if he would be a popular physician, which is the synonym for a well-paid one.

I presume the thought has more than once flamed up above the horizon of your minds: Is the orator of to-night among the fortunate? If success means having rest neither by day or night, if it means a large monthly order from the druggist, if it means a stable full of tired horses, if it means a ceaseless combat with little and big distempers, I may modestly assert, that in granting me my sheep-skin, the C. P. and S. issued letters patent for a snug income derived from the truck patches of Anne Arundel. This success I owe primarily to the teachings of Opie, Bevan, Latimer, Friedenwald, Rohe, and Simon, whose signatures still ornament the blue ribboned parchments you fledglings of the college will receive tomorrow—of the lamented Lynch, Coskery, Gundry and Erich, who have, alas, passed to the Silent Land. And lastly to Arnold, dear and honored, the learned and venerable Professor *Emeritus* of this school.—To them, and to a constant forage in current medical literature. Secondarily, I am a seventh son, which has brought me the enviable reputation of healing, once only accredited to kingly touch and vision. It is my lucky stone, my mascot, my rabbit's foot, my mole's claw; what the sacred rattle is to the Guianan Piai, his suction to the Australian *Bilbo*, his goggles to the Chinese *medicus*, his magic snake to the Tongan doctor, his Kava bowl to the Kaffir prophet, or what his drum is to the Indian medicine man, does this



lucky accident of birth make me in the eyes of superstitious crones. So, gentlemen, convince your patrons that you too are a lucky number in family, as well as census enumeration, and your fortune is made. It is only "a windmill put out to catch the breeze of popular favor," although in my individual instance a verity, but I assure you it works like a charm.

Believe me when I say that till life's latest day I shall remember this hour as one of my happiest, yet not without alloy, for as "it is not granted to man to *love* and to be *wise*," neither is it granted him to orate without a dread of that criticism which is passive; I therefore bespeak your kindest thoughts, and protest that I sit uneasy upon my temporary throne amid the great, the brilliant, the governing luminaries of our college; but when greatness is thrust upon one, what can one do but submit to the fiat of the *dii majores* for a brief minute? I ask this with certainty of accorded favor, for I see here many faces dear to my adolescent heart; a nascent affection that will cease only when "the earth shall claim her own, and sleeps my day in silence there."

What shall I wish for you? All the gifts in the teeming cornucopia of the gods? That you may say that *we* may individually be high lights thrown upon the mezzotint of our surroundings.

Then I beseech this boon; may we fulfil our dreams.

Long may we flourish,  
And coming centuries nourish,  
The Alumni of the C. P. and S.  
In gracious growth may we excel,  
In worth, in wit, in fame as well;  
Till every land our feet caress,

Till from the broad earth's farthest  
rim

May rise a full, full-throated hymn  
Harmonious chain which links no less  
The Alumni of the C. P. and S.

#### CODEINE.

Codeine is a drug that undoubtedly receives from the medical profession far less attention than its many good qualities demand. It is an undoubted anodyne, and has the advantage over morphia that it does not check the secretions, does not produce disagreeable after-effects and is not likely to lead to a habit. On account of this last characteristic it is a good deal used as a substitute for morphia in some of the cures for the opium habit, but as far as can be ascertained this method of treatment is never completely successful, as the patient's real struggle begins when the codeine is stopped. As an ingredient in cough mixture the drug is a most excellent one and an admirable substitute for morphia. A disease in which it has often been pronounced a specific is diabetes mellitus, where it is given in doses double or even more than double those ordinarily recommended. Indeed it is said by some writers that no result can be expected from a dose less than a grain, although the regulation dose is not over one-half that quantity.—*Northwestern Lancet*.

In simple atony of the uterus ten or fifteen drops of the wine of ipecac, given at intervals of ten minutes, will cause a marked activity in uterine action. Its effect is not tetanic, the contractions being of a regular normal type.—*Annals of Gynec. and Pædiatry*.



URTICARIA.\*

BY J. ABBOTT CANTRELL, M. D.,

Instructor in Dermatology in Jefferson Medical College, Dermatologist to the Philadelphia Hospital, and to the St. Agnes Hospital, Philadelphia.

This evening I hope to place before you some of the conditions that are present in the above disease and also refer slightly to the diseases or derangements that are likely to produce them. The lesion here may range from  $\frac{1}{2}$  inch to 1 inch in diameter, but most frequently we see it a half inch in diameter or in size corresponding with the nails of one's fingers.

This lesion, the pomphus, or so-called wheal, is a firm, flat, constricted spot, being reddish at first and remaining so, or after a short while becoming white upon the summit, the base alone showing the heightened coloration; it may occur spontaneously or may be produced by the scratching consequent upon the itching over the site of a lesion yet unformed.

It may appear suddenly and may disappear in a like manner.

The lesion itches intolerably and this is not influenced by the scratching, except to make the irritability arise to a higher pitch.

Upon the disappearance of the lesion we have no sign of such a condition having existed.

As the disease does at times show variations as to lesions produced we will examine those that appear.

Urticaria papulosa is witnessed more frequently in childhood, although it may appear in the adult, having possibly in connection with it some vesicles and crusted pustules.

The lesion here is a veritable papule

and does not differ from that found in other diseases of the skin except perhaps in contour, the lesion is raised and is somewhat more persistent than the previous form.

Its appearance in the child may be explained thus, that the skin of children is more ready to resent irritation than that of adults and instead of having merely a serous effusion, we have actual inflammatory effusion into the papillæ, and consequently a papule remains. It is found to be more abundant around the lower part of the back and buttock, but may be produced wherever scratching is performed,

Without inquiry we will not be aware of the existence of the wheals in this manifestation, and if they should be present they will be pink instead of white. It is more persistent in summer.

Urticaria tuberosa, urticaria gigans, or the so-called giant urticaria, where the lesions are found to be as large as a goose egg, as has been witnessed by Crocker. I myself have seen a case in a child of 12 years where the lesions were situated upon the scalp and resembled hen's eggs placed under the skin.

In this form the lesions are more persistent and you certainly can imagine what the objective symptoms would be.

Urticaria œdematosa is found where tissues are lax, as upon the face and around the eyes, the parts become very swollen, the tongue so much so as to almost cause suffocation, but fortunately this condition generally subsides in a few hours.

Quincke's disease, or acute circumscribed œdema; the parts may swell into a large tumor upon the face, and there

\*Read before the J. M. DaCosta Medical Society, May 26th, 1893.

may be swelling of other parts of the body from subcutaneous œdema; cases have been reported by Hertzell, Horwitz and others.

Urticaria subcutanea is where the subjective symptoms may be present, but without the appearance of the wheals; this is generally limited to the loins and thighs. But a case of this where the condition was present on the abdomen was reported by me before this society last June.

Urticaria hæmorrhagica, or purpura urticans, is where the lesion may be a wheal and be very dark in color, on account of the bloody effusion, and where this condition attacks the mucous membranes the hæmorrhage is likely to be very profuse.

Urticaria factitia, where the lesion does not show itself upon the skin, but the skin is in such an irritable condition that a lesion may be produced by simply running your hands over the skin of the individual; by doing this you can produce welts; that is, the parts may look as if a cord was placed under the skin.

Urticaria bullosa is witnessed after the serum reaches the upper layers of the rete, elevating them into a bulla.

Urticaria pigmentosa occurs for the most part in young children, but is occasionally witnessed in adult life; it is the appearance of pigmentation upon the site of all existing lesions; this may be permanent or remain only a short time after the appearance of the urticarial tendency.

Now to study the conditions that are likely to produce this appearance of urticaria, whether the lesion produced is one or the other mentioned.

We may study them under the following heads.

Direct irritation; that is, from anything whatsoever coming into contact with the skin, such as the common stinging nettle, the ordinary jelly-fish, insects of all kinds, as fleas, bed-bugs, caterpillars, and from violent scratching from any cause—e.g. scabies, pediculosis or eczema, and any change of atmosphere. Indirect irritation, as from certain articles of diet: shell-fish, mussels, crabs, oysters, meats, sausages, pork, mutton. Fruit, such as nuts, almonds strawberries. Fungi, such as mushrooms; and possibly oatmeal.

Medicines often play a part in the production of this condition—copaiba, cubebs, cinchona and quinine, morphine, turpentine, salicylic acid, valerian, chloral, antipyrine and digitalis.

Worms often participate in its production, especially intestinal worms. Persons of the gouty diathesis are prone to the disease.

Diseases of some internal organs, such as those of the uterus and its appendages; some women suffer with it at each pregnancy.

Disease of the stomach of whatsoever kind, especially if it depresses the individual much.

It is likely to be mistaken for scabies, erythema nodosum, erythema papulosum and tuberculosum, eczema, dermatitis herpetiformis, erysipelas.

Scabies we may safely diagnosticate because of the characteristic burrow, which may by close inspection easily be found.

Erythema papulosum and tuberculosum; lesions may enlarge on the periphery, are more of a burning character than itching; are symmetrical.

Erythema nodosum; lesions may enlarge on the periphery, and the tumor is very painful.

Pediculosis; the minute puncta and the scratch marks, and the appearance of the parasite on the clothing of the individual.

Eczema; more likely to form patches, some history of moisture, and the more chronic condition of the parts affected.

Erysipelas; enlarges on the periphery. high fever, and the consequent constant puffiness.

Dermatitis herpetiformis; the multiplicity of the lesions, papules, pustules, vesicles, bullæ, etc., and their independence of the ingesta.

The treatment of this affection, in an acute attack, which is due to the ingestion of irritating substances, is best by an emetic, if seen early, and the use of saline aperients—such as the *mistura ferri acida*, of which you have often heard. In the majority of cases these simple preparations will suffice, and you must be careful not to allow it to go into the chronic form, by giving the persons bland and unirritating articles of diet.

In a chronic case; every organ of the body must be carefully examined; the habits of the individual; the urine is also examined, but in the majority of the cases it will be found that disorder of the alimentary canal is where the disease generally starts from.

In these cases the alimentary must be cleansed by an emetic, as in the acute form, and the use of saline aperients; all alcoholic stimulants must be interdicted; in fact, all fermentable articles, as pastry and highly seasoned food; patient is instructed to notice if any special article

of diet or other circumstances leads to an outbreak. The action upon the intestinal canal may be kept up by using a pill of aloes, belladonna and nux vomica, which is given every night, or the *Lady Webster* (aloes and mastich) which may be given after the mid-day meal. Diuretics may be found of decided service.

Often in the treatment of these cases you will be at a loss to find a cause and these cases you will treat on general principles; the use of tonics, such as arsenic in small and continued doses; quinine and bromide of potassium have given decided satisfaction at times in my hands.

For the irritation upon the external surface of the skin, antipuritics are indicated, alkaline baths, such as the sodium or potassium carbonates ( $\text{ʒii}$  to the bath or increased if necessary) and at times one of the following will be found of service:

Carbonic acid ( $\text{ʒiii}$  to pint). *acidi borici* (saturated solution), naphthol (gr. x-xv to  $\text{ʒi}$ ) menthol (gr. ii-x to  $\text{ʒi}$ ) liquor carb. detergens ( $\text{ʒii-ʒiii}$  to  $\text{ʒviii}$  of water).

1010 South Third St.

#### GLYCERINE.

Glycerine is highly recommended as a dressing for the umbilical cord. The old method of dressing with lard leaves an unhealthy sore, which may be the starting point for a number of infecting processes, and the modern antiseptic dressings preserve the cord so well that it may not dry off until the tenth or twelfth day. Glycerine, while being antiseptic, has also a distinct effect in promoting cicatrization.—*Ex.* [Undiluted glycerine is sometimes very irritating.—Ed.]



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BALTIMORE, JUNE 10, 1893.

### Editorial.

#### THE ANNE ARUNDEL COUNTY MEDICAL SOCIETY.

In accordance with a plan which we laid out some time ago, of securing for our JOURNAL a brief history of each of the county medical societies up to date, we publish the following, which has kindly been prepared for us by Dr. Chas. B. Henkel, of Annapolis.

We offer it with all the more interest in view of the appointment of Annapolis for the next semi-annual Faculty meeting.

##### HISTORY OF THE SOCIETY.

Late in the year 1889 a call was issued to all the physicians residing in Anne Arundel County, inviting them to meet in this city on the first Tuesday in January, 1890, for the purpose of organizing a medical society.

In answer to the call the following physicians met in the parlor of the Maryland Hotel (in this city) and the

Society was organized by electing the following officers and committees:

President, Dr. Abram Claude, of Annapolis; Vice-President, Dr. W. Q. Claytor; West River; Rec. Secy., Dr. B. R. Davidson, Davidsonville; Cor. Secy., Dr. G. Wells, Annapolis; and Dr. J. W. DuBois, Treas., Millersville. Finance Committee: Dr. H. M. Revell, Dr. W. C. Claude, Dr. C. B. Henkel. Executive Committee: Dr. H. B. Gantt, Dr. S. D. Kennedy, Dr. J. W. DuBois.

A committee was appointed by the President to draft a "Constitution, By-Laws and Fee Table" for the Society. This committee, Drs. W. C. Claude, Geo. Wells and J. W. DuBois, reported at the next meeting that they had prepared the By-Laws and Constitution and Fee Table and the Society adopted the same as prepared by the committee.

##### OBJECT OF THE SOCIETY.

The Society has for its object the cultivation of medical science.

##### TIME OF MEETING.

Regular meetings are held bi-monthly on the first Tuesdays of January, March, May, July, September and November.

##### ANNUAL MEETINGS.

The annual meeting for the election of officers is held on the first Tuesday of January.

##### THE EXECUTIVE COMMITTEE.

This committee conducts the general business of the Society and also arranges the programme of each meeting. Also reports to the Society as to the eligibility of candidates for membership.

##### MEMBERSHIP.

Active members: Any member of the medical profession in good standing and residing in Anne Arundel County may become an active member of the Society.

CORRESPONDING MEMBERS.

Any member of the medical profession not residing in Anne Arundel County may be elected a corresponding member of the Society.

The applications of all candidates for membership are referred to the Executive Committee and upon said committee reporting, a ballot is taken.

No candidate who has been rejected can be proposed again within one year of said rejection.

Applications for membership must be accompanied with the initiation fee (\$1), also the dues (\$2), for first fiscal year of membership.

The physicians present at the organization meeting were the following:

From Anne Arundel County: Drs. George Hammond, Cronsville; J. W. DuBois, Millersville; W. Q. Claytor, West River; Samuel Anderson, Woodwardville; H. M. Revell, Arnolds; C. M. Cheston, West River; H. B. Gantt, Waterbury; B. R. Davidson, Davidsonville.

From Annapolis City: Drs. Abram Claude, A. Roland Walton, S. Daniel Kennedy, George Wells, W. G. Tuck, W. Clement Claude, Frank H. Thompson, Chas. B. Henkel.

NEW MEMBERS.

The following were elected during the past four years: Drs. C. S. Johnson, Elvaton; Elijah Williams, Armiger; Thomas H. Brayshaw, Glen Burnie; George Emmons Marchand, Annapolis; J. Chester McPherson, Severn; C. R. Winterson, Patapsco Station.

ANNUAL MEETING, 1893.

The President, Dr. Samuel Anderson, read an exhaustive and very interesting paper on "Typhoid Fever," and the

following officers were elected to serve during the present year (1893): Dr. Samuel Anderson, President; Dr. Geo. Wells, Vice-President; Dr. B. R. Davidson, Recording Secretary; Dr. Charles B. Henkel, Corresponding Secretary; Dr. Frank H. Thompson, Treasurer.

Thanks of the Society was voted the President for his able paper on "Typhoid Fever."

A regular monthly meeting was held in March, 1893.

MARCH MEETING.

Dr. George Wells read a complete, able and interesting paper on "Asiatic Cholera," for which he received a vote of thanks of the Society.

A committee, Drs. McPherson, Henkel and Brayshaw, was appointed to attend the meeting of the Medical and Chirurgical Faculty in April and invite the Faculty to hold their next meeting in this city.

A dinner at the Maryland Hotel followed the meeting.

A regular monthly meeting was held in May, 1893.

MAY MEETING.

Dr. Thomas H. Brayshaw read a paper on "Diphtheria," which was discussed by the Society and for which the doctor received a vote of thanks.

The committee appointed at the last meeting to attend the session of the Medical and Chirurgical Faculty in Baltimore reported, through Dr. Charles B. Henkel, that they had extended an invitation to the Faculty to hold their next meeting in this city and also that the Faculty had accepted the invitation of the Society and would hold their semi-annual meeting in this city in November.

### A MEMORIAL WARD FOR CHILDREN.

Amid the warring and discordant elements of earthly life there is one thought before which all discord ceases—the thought of suffering childhood.

About the portals of the Children's Hospital, with its long rooms of little white cots, there hovers a sacred spell which even the most irreverent must own.

It is therefore with unusual pleasure that we learn from the daily press that on Sunday, May 27, "The Jennie Ritchie Smith ward for children was dedicated at the Maryland University Hospital with appropriate ceremonies, which were conducted by the Rev. Dr. Joseph T. Smith, the venerable grandfather of the little girl in whose memory the ward is established. The ward is beautifully equipped with neat little enameled iron cribs with brass mountings, the walls appropriately painted and ornamented and hung with suitable pictures, and a memorial tablet containing the name and the date of death of Jennie Ritchie Smith. The ward is the gift of Dr. and Mrs. Joseph T. Smith, of 1010 Madison Avenue, the parents of the little girl. A large number of people were present, among whom were members of the Woman's Auxiliary Board of the Faculty of Physic and many friends of Dr. and Mrs. Smith."

The medical friends who sympathized with Dr. Smith in his sad bereavement some years ago will now rejoice with him, in that he has devised such a beautiful memorial and has set such a noble example to his fellow-physicians.

This is the time of sun spots. Readers will watch their heat centres.

### Reviews, Books and Pamphlets.

*The Obstetric Examination;* A short guide for physicians, students of medicine, midwives and students in midwifery; by PROF. E. CREDE, M. D., and PROF. G. LEOPOLD, M. D., Private Medical Councillor; edited by J. Clifton Edgar, M. D. Price twenty-five cents. L. Hydel, publisher, 212 E. 50th St., New York. This is an extract from the fifth edition of Crede and Leopolds' text-book of obstetrics for midwives.

The pamphlet sets forth in 16 octavo pages, the external examinations as made by these eminent teachers and the antiseptic regulations enforced by them.

Several colored prints are given, illustrating the manipulations required in external examination.

*Medical Pocket Atlases; Obstetrics.* Part 1: Labor, delineated in 98 plates; by O. SCHAFFER, M. D., Assistant at the University Frauen-Klinik in Munich. Translated and published under the supervision of J. Clifton Edgar, M. D., Adjunct-Professor of Obstetrics in the University of the City of New York. L. Hydel, publisher, 212 E. 50th St., New York.

The aim of the author is to set forth in successive series of illustrations, with very brief explanations under each, the progress of labor, normal and abnormal, in such a manner that the student may clearly comprehend each movement, position and manipulation.

The plates are certainly very clear; and are arranged in progressive series in a very admirable way. The book is made coat-pocket size.



The publisher informs us that he has in preparation similar atlases on "Pregnancy" and "Gynæcology;" and that atlases on "Ophthalmology," "Bacteriology and Infectious Diseases," "Surgery," "Cutaneous and Venereal Diseases," "Diseases of the Naso-Pharynx," "Otology," and "Pathological Anatomy" will follow.

*Napheys' Modern Therapeutics, Medical and Surgical*; Also Diseases of Women and Children. A compendium of recent formulæ and therapeutical directions from the practice of eminent contemporary physicians, American and foreign. Ninth edition, revised and enlarged. Volume 2: General Surgery, Gynæcology and Obstetrics; by Allen Smith, M.D., Professor of Pathology, University of Texas, Galveston; late Lecturer in Urinology, University of Pennsylvania; and J. Aubrey Davis, M.D., Assistant Demonstrator of Obstetrics; University of Pennsylvania, etc., 8vo., pages 1112. Half Russia, \$6 net. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street, 1893.

We have reviewed with much pleasure this treasury of useful formulæ and therapeutic hints from the writings of eminent medical practitioners. It forms a valuable book of reference to which the physician may turn, in difficult cases, for therapeutic suggestions.

The volume, with its predecessor in the series, makes a handsome addition to the doctor's library; and is well worth the inspection of every progressive physician and surgeon, especially of those who are hindered by the breadth of their field of practice from securing many standard works in each department of medicine.

*Medico-Legal Journal*; a quarterly, \$3.00 per volume. Original articles, portraits and sketches of eminent medico-legal jurists.

*Bulletin of the Psychological Section of the Medico Legal Society*; a quarterly, at \$1.50 per annum. Send subscriptions to the *Medico-Legal Journal*, 57 Broadway, New York City.

### Medical Progress.

#### HYSTERECTOMY.

In *American Surgery and Gynæcology*, April, Dr. Lanphear describes a method of complete ablation of the uterus which he has found valuable in several cases. The bowels are opened for two nights before the operation, generally by compound licorice powder. A vaginal douche of hot boric acid solution is given the evening before operation. One hour before operation a copious rectal enema is given with repetition of the vaginal douche.

When completely under the anæsthetic the abdomen and vulva are shaved and thoroughly scrubbed with soap and water; then dried and washed with sulphuric ether; then rubbed with saturated solution of permanganate of potassium until of a deep mahogany color; decolorized by a strong solution of oxalic acid and finally doused with a solution of bichloride of mercury, 1 to 1000. The patient's legs are wrapped in blankets, covered with bichloride towels and held widely apart by a nurse; the vagina carefully washed out with the bichloride solution followed by hot water. Hands of operator and assistant having been cleaned and the abdomen protected by hot bichloride

towels, as in any other laparotomy, an incision is made through the abdominal wall close to the middle line, four inches or more in length. The ovary and tube of one side are caught and pulled into the opening, and a clamp applied to their outer side, but as close to the uterine body as possible; a heavy catgut ligature is passed through the broad ligament, tied, and a cut made between the ligature and the clamp; this suturing may be continued downward into the pelvis as far as convenient. The other side is then treated in the same manner, when the uterus, with its attached tubes and ovaries, may readily be brought up into the opening. Unless this preliminary suturing and dividing is done much valuable time will be lost in attempting to urge the fundus into view. the extreme tension of the broad ligaments absolutely prohibiting; because of this only one side of the uterus can be seen at once and no amount of force can lift it up until the broad ligaments are divided. As soon as this is done the circular shape of the bladder disappears, the organ extending itself outwards and backwards, the corrugations of peritoneum upon its border ceasing to be prominent. The fundus is now tilted backward, a cut made transversely across the uterus, through the peritoneum, and separation of bladder from womb accomplished methodically and completely. This line of incision should be made just behind the vesico-uterine fold, which is easily recognized by touch; the dissection is done partly by fingers and partly with some blunt instrument (I prefer the end of my blunt-pointed curved scissors used closed), the bladder being pressed away little by little, below and in front.

When the region of the os tincæ is reached one finger is slipped into the vagina, the exact location determined, and the scissors pushed through the mucous membrane; this opening is extended across the anterior surface of the cervix as in the initial step of vaginal hysterectomy, save that the cut is made from above instead of below. The uterus now being pulled strongly forward a similar separation of uterus from rectum is made, but not nearly so much care is required, as the distance is short and perforation of the rectum not easy.

When the opening through the cul-de-sac of Douglas is complete the sides may be ligated and the uterus cut away; this is about the same method of "total ablation" as done by M. Guernonprez; but in cases of large myomata or myo-fibromata, especially if accompanied by small pelvises, this is not an easy matter, and it requires much time, even in the most favorable cases, an item of grave import in weak anæmic patients. At this point my modification has proven of service. The anterior and posterior openings into the vagina having been quickly and satisfactorily made, the uterus is given into the hands of an assistant, who pulls it upward and to one side; a Polk's clamp (such as used in vaginal hysterectomy) is inserted through the vagina close to the uterus, with one hand, while the other is within the pelvis to guide the blades into place. The whole pedicle being seen to be within the grasp of the blades, the clamp is closed, the uterus carried over to the other side, the fellow clamp applied in the same manner, and the uterus, tumor, tubes and ovaries cut away with scissors. Irrigation with hot water is made, the parts dried, gauze



drainage put into the vagina and the abdomen closed with catgut sutures, with the usual dressing of iodoform, bichloride gauze, cotton and surgeon's plaster. The clamps are treated as in cases of vaginal hysterectomy.

#### FOR CONSTIPATION.

In the *Texas Courier-Record*, April, Dr. Howard, of Waco, gives the following notes on the treatment of constipation:

No drug in the past has been more generally used for the cure or relief of constipation than aloes, its action on the large intestine giving it the preference. Of late years nux vomica and belladonna have had quite a rage, and justly so, from my experience with them. Cascara is the one drug now in highest favor with many eminent practitioners. Calomel, rhubarb, ipecac, podophyllin, colocynth and senna are each useful to meet certain indications.

Each case should be separately investigated and the drug best suited to the cause—to meet the pathological condition—prescribed. No intelligent physician would think of giving the same drug for impaction and dilated stomach. Pepsin often acts efficiently in correcting constipation, because it meets the pathological indication. Stomach indigestion, mania, paralysis, mental worry, demand treatment of the central nervous system as well as emptying the bowels.

The treatment for patients of otherwise healthy condition is water. Take a glass of water, hot or cold, on going to bed, and in the morning before breakfast, will almost always correct this inaction or constipation. With this, have

a regular hour to go to stool, one hour after breakfast preferably; thus encourage one action a day and the habit will soon be established without one dose of medicine. When medicine is required I prefer cascara or aloes; one of my favorite prescriptions is aloes, belladonna and nux vom. in pill. Aromatic cascara has done me excellent service in many cases. The duty of the physician is to find the pathological cause and meet it with the physiological remedy.

#### THE EYE DISORDERS OF LACTATION.

In a review of the diseases of the eye in gynæcology, Dr. Ramsay (*Lancet*, April 15) says: I have only time to refer very briefly to those eye affections which are more or less the result of lactation. Whether it be mere coincidence or not, cases are met with every now and then where blindness, due to atrophy of the optic nerve, occurs in women who have nursed several children in rapid succession; but by far the most frequent conditions met with are functional disturbances due to impairment in the power of accommodation. It is not surprising that the effort to secrete, for several months, milk sufficient for the nourishment of a healthy infant should not be accomplished without considerable exhaustion of the system. The muscular apparatus of the eye shares in the general weakness, and a patient who, previously to the birth of her child, was able to see clearly and comfortably, now complains that small print gets blurred and confused when looked at, and that the effort to read is accompanied by distressing sensations in the head and by pain, lacrymation, and even redness in the eyes themselves. That these symp-



toms are due to weakness in the power of accommodation and convergence is not difficult to understand when one recollects the mechanism by means of which these acts are accomplished. Obviously, therefore, long-sighted women suffer most frequently. It will at once be evident that the proper and only treatment in such cases is to supplement the power of the ciliary muscle by the use of convex glasses to be worn for all near work; and, as a rule, when once the spectacles are properly adjusted the unpleasant symptoms gradually disappear, and the relief obtained is real and lasting. In addition, every effort should be made to improve the general health, and in extreme cases it is necessary to wean the child. A scratch on the cornea—not an unusual thing for a mother to receive from the nails of her infant—is, of all the slight injuries to the eye, one of the most difficult to heal. There seems in some cases a marked tendency to suppuration and accumulation of pus in the anterior chamber. I simply mention this for the purpose of emphasizing the fact that even the most trivial injury to the cornea of a woman who is suckling a child demands prompt treatment. I have seen episcleritis appear for the first time when the health of the patient was enfeebled by prolonged lactation and can confirm Power's observation that women who are nursing children are predisposed to the occurrence of "obstruction of the lacrymal ducts and lacrymal abscess."

I have drawn attention to this subject at considerable length, because, although there are several special monographs which treat of it exhaustively, yet in the ordinary text-books it is dealt with very briefly.

#### TYMPANITIC AND SILENT LUNG IN PNEUMONITIS.

After relating a case with the above peculiar features, Dr. Steell (*Lancet*, April 29th) comments thus upon them:

The unusual features of the case were (1) the silence of respiration over the consolidated lobe and (2) the tympanitic quality of the percussion sound over the lower lobe of the affected lung. Now, with regard to the tympanitic quality assumed by the percussion resonance of the left lower lobe, the first conjecture in explanation of this occurrence was that we had to do with the communicated resonance of a distended stomach. We know that sometimes the stomach note is elicited on percussion over the greater part of the left side of the chest. Under the circumstances the percussion dulness of the heart may be quite lost, and this too, when the organ is actually enlarged and its beating can be seen under the very spot which yields tympanitic resonance.

The phenomenon in question was referred to by the late Dr. Walshe as "horizontal conduction." Careful examination in our patient did not, however, confirm this explanation of the abnormal resonance and left no doubt, in fact, that the tympanitic resonance was of pulmonary and not of gastric origin. We are quite familiar with a similar phenomenon in the upper lobe of the lung when the lower lobe is consolidated. When the lower lobe of the left lung is consolidated we expect indeed to find the resonance of the corresponding upper lobe assuming tympanitic quality, just as it does in the case of pleuritic effusion. It is a fact, of which I hope you are all aware, that

when the normal vesicular structure of the lung contains less than the normal amount of air its resonance assumes a tympanitic quality. Here is Skoda's dictum: "That the lungs, partially deprived of air, should yield a tympanitic and, when the quantity of air in them is increased, a non-tympanitic sound appears opposed to the laws of physics; the fact, however, is certain." The healthy lung in the chest, as you know, yields a *non-tympanitic* resonance on percussion, but a healthy lung, if percussed on the post-mortem room table, will be found to yield a *tympanitic* resonance. I will not attempt to explain the phenomenon of the assumption of tympanitic quality by the resonance of the unaffected lobe in cases of lobar consolidation. When the lower lobe is consolidated, it is the rule, as I have said, for the upper lobe to manifest the percussion change indicated, but the case related is the first in which I have observed assumption of tympanitic quality by the resonance of the lower lobe in the presence of consolidation of the upper lobe. Bear in mind that in the cases referred to there is no evidence of the lobe which yields tympanitic resonance being itself the seat of partial consolidation. Coming now to physical signs, the left side of the chest at the upper part moved less freely in respiration than the right at the same level. On percussion there was intense dulness over the upper lobe of the left lung, whilst the lower lobe of the same lung yielded tympanitic resonance. This last was audible at the back and was evidently *not* communicated stomach resonance.

Over the greater part of the dull area in front there was no breath sound to be heard, but at the lower border of the

dull area a few small bubbling sounds were audible with indeterminate breath sound.

What explanation can be given of the absence of breath sound in rare cases of pneumonia? Cases with persistence of "silence" are certainly rare, but if you frequently auscultate ordinary cases of pneumonia, as one can do when one is resident in hospitals, you will find that occasionally the bronchial breath-sound usually audible is absent. Moreover, and this is very important for after-considerations, you will often be able to restore the bronchial breath-sound by causing the patient to cough repeatedly.

After an elaborate discussion our author decides that the absence of "bronchial breathing" over the consolidated lung was due to occlusion of the tubes by extremely viscid mucus which was a feature of the case, so that the respiratory vibrations from the trachea and bronchi could not be conveyed by an unbroken column of air to the consolidated lung. By this also the restoration of "bronchial breathing" obtained after coughing is explained.

#### SHE FUSSES TOO MUCH.

The *National Medical Review* gives us the following character-sketch which will appeal to every reader:

We know what is the matter with him, and have known it all along. He is very delicate, and the least draught of air will throw him into a chill. He suffers from cold feet and darting pains and has the most miserable kind of an appetite. He is either greatly depressed or highly elated and has an abiding conviction that he is soon to be called to render up his account. He believes in faith-cure and Christian science, yet he is the constant patron of



his family physician, thanks to his faithful wife. Poor woman! She warms his shoes for him every morning, for fear they may be a trifle damp. She gets all the clothing ready so he may jump into them quickly without too long exposure of the body to the air. She feels of his head for fear it may be too hot and chafes his feet that the circulation may be good for the day. We might prolong the picture in this line for a whole page and yet it would not be overdrawn. The poor careworn, anxious wife declares "he is so delicate," and he, the fool, thinks he is. Now what is the diagnosis in this case? She fusses too much! If such men had no one to fuss over them, they would become strong and well within three months. We often write of the nervous, hysterical woman; but deliver us from the grunting man spoiled by the mistaken kindness of a devoted wife.

#### NATIONAL BUREAU OF MEDICAL BIBLIOGRAPHY.

It may not be generally known that the Library of the Surgeon General's Office, U. S. A., is the largest medical library in the world, and contains more than three-fourths of all the medical literature published, and 90 per ct. of the medical literature of the last ten years, yet such is the case. All this storehouse of valuable information is indexed and classified up to date, under its appropriate subject; and it is now, through the medium of this National Bureau, for the first time made accessible to the busy practitioner, lecturer and author the world over.

The persons at the head of this Bureau are residents of this city and have had over a quarter of a century's experience in this line of work. They enter upon the management of this bureau

with confidence of rendering a great service to the medical and literary men and women of the land at a comparatively small cost to them.

State clearly what is the information desired and full particulars as to terms, etc., will be furnished promptly. Address the Bureau at 102 Ninth Street, S. E., Washington, D. C.—*National Medical Review*.

#### Medical Items.

The Brooklyn Home for Habitues, Dr. J. B. Mattison, Director, has been removed to 188 Prospect Place, near Prospect Park.

American Association of Genito-Urinary Surgeons.—The seventh annual meeting will be held at the Four Seasons Hotel, Harrogate, Tenn., on Tuesday and Wednesday, June 20 and 21, 1893.

The Board of Medical Examiners will hold an extra examination June 15, 16 and 17. Applications for license should be made on or before June 13. W. F. Lockwood, Secretary, 201 W. Madison Street.

At a recent session of the Library Committee of the Medical and Chirurgical Faculty, Dr. C. Hampson Jones, 25 W. Saratoga St., was re-elected librarian of the Faculty and registrar of the Directory for nurses.

A physician was represented in Egyptian hieroglyphics by the picture of a duck. Our advices do not state whether this was because he was looked upon as a quack, or because he was a favorite among the fair sex.—*Medical Record*.

At a meeting of the board of directors of the New York Post-Graduate Medical School, held on May 17, Dr. A. Palmer



Dudley was elected professor of diseases of women, Dr. George M. Edebohls professor of diseases of women, and Dr. George T. Elliot professor of diseases of the skin. Dr. J. West Roosevelt has resigned his position as professor of clinical medicine.

Presbyterian Eye, Ear and Throat Hospital; Monthly report for May.—The number of new cases entered for May, 1,092. The daily attendance aggregated 3,180, giving an average daily attendance of 122 patients for each working-day of the month. The number of operations for the month was 201, an average of 9 operations for each day. The growth of the hospital seems continuous. Already the number of new cases entered on the hospital books since the 1st of January is 5,100, an average of 1,000 new patients each month. J.J. Chisolm, M. D., Surgeon-in-Chief.

Too many persons perish unnecessarily from being overpowered by smoke, in fires. A simple protection, like that described below, ought to be in readiness by every sleeper. This is what a woman says in the *Helper*: For years, I have never slept without seeing that a couple of silk handkerchiefs hung near my toilet-stand, and that the bowl was half full of water. When I was a young woman, not out of my teens, I was in a hotel which took fire. I should have suffocated if my uncle, with whom I was traveling, had not thrown a wet silk handkerchief over my face. Thus protected, I followed him through the hall filled with choking smoke and down the stairs to safety. I have taught the practice to my children, and it has become a habit with us all. You want good big ones and

they must be wetted thoroughly; then you may, if forced to do so, endure the thickest smoke for a considerable time.—*Ex.*

Mr. Wanamaker is now a private citizen, but he carries with him into retirement the proud consciousness of having issued the most comely and picturesque postage stamp ever turned out by an American Postmaster-General. The Wanamaker stamp is not only a thing of beauty as to design and coloring but is generous in its dimensions and is smoothly plastered on the back with an article of mucilage unsurpassed in sticking qualities, pleasing to the taste, and said by experts to be wholesome and nutritious in the highest degree, being composed of the best gum arabic and other meritorious and strictly pure ingredients which the most delicate system can assimilate not only without injury but with positive benefit. And, although Mr. Wanamaker himself does not claim that the mucilage of his justly admired stamp has medicinal qualities, it may turn out that its frequent use will prove to be a specific for dyspepsia, heartburn, nervousness, gout, rheumatism, neuralgia, backache, sore throat, coughs, colds, influenza, sore eyes, salt rheum, ingrowing toe-nails, and that tired feeling (Hood's Sars.) If it does, the American people will rise up as one man and bless his memory.—*St. Louis Clinique.*

The training school for nurses of the Johns Hopkins Hospital graduated, June 2nd, a large class of pupils. Among the new enterprises in this department are the publication of two text-books for nurses. "Nursing, its Principles and Practice" by Miss Isabel Hampton, and

"Invalid Cooking," by Miss Mary A. Boland; and the institution of a Nurses' Conference which will convene in Chicago under the direction of Dr. John S. Billings and Miss Isabel Hampton.

A reception followed the graduation exercises.

The graduates were: Sarah Gordon McDonald, of Ontario; Charlotte Ewell, of Virginia; Mary A. Collins, of Pennsylvania; Henrietta Gertrude Richardson, of Maryland; Johnetta B. Sanger, Washington, D. C.; Dora Hamilton, Nova Scotia; M. Agnes Pease, of Maryland; Mary A. Murray, Connecticut; Alice McDonald, Quebec; Ruth Maynard, of Maryland; Susan Carroll, Arkansas; Julia King, Bermuda; Ethel L. A. Barwick, Ontario; Wilhelmina A. Wade, Virginia; Ada M. Carr, Ontario; Hannah M. Neill, Scotland; Harriet Forman, Maryland; Sarah Heath Cabaniss, Virginia; Ida F. McArthur, Ontario.

The Medical Society of the District of Columbia proposes to celebrate on the 16th of February next the 75th anniversary of its incorporation. Drs. Busey, Stowell, Smith, McArdle and S.S. Adams, Ober and Snyder have been appointed to arrange for the celebration. They have accordingly made the following report, which has been unanimously adopted by the society:

To deliver an address entitled "History of the Society," Dr. W. W. Johnson; to deliver an address entitled "History of the Medical Colleges in the District of Columbia," Dr. Thomas C. Smith; to deliver an address entitled "History of the Hospitals of the District of Columbia," Dr. J. Ford Thompson."

The following are the invited guests: The President and Vice President of the United States; the Speaker of the House

of Representatives; the Chairman of the Committees on the District of Columbia of the Senate and House of Representatives; the Presidents of the University of Georgetown, the Columbian University, Howard University, and the Chancellors of the National University, the Catholic University of America, and the American University; the Surgeon-General of the Army; the Chief of the Bureau of Medicine and Surgery of the Navy, and the Supervising Surgeon-General of the United States Marine Hospital Service. The committee also recommend that an invitation be sent to each of the following medical societies in this country, which were organized more than seventy-five years ago and are now in existence, to send representatives, each one, to this anniversary celebration, as follows:—

New Jersey Medical Society, organized 1766; Massachusetts Medical Society, organized 1781; College of Physicians of Philadelphia, organized 1787; New Hampshire Medical Society, organized 1791; Connecticut Medical Society, organized 1792; Medico-Chirurgical Faculty of Maryland, organized 1799; New York Medical Society, organized 1806; Albany Medical Society, organized 1806, New York County Medical Society, organized 1807; Rhode Island Medical Society organized 1811; Vermont Medical Society, organized 1814.

The committee also recommends that the transactions and proceedings relating to the celebration of the seventy-fifth anniversary be published in pamphlet form for the use of the members, and that the committee be authorized to appoint an editor of this publication.

"The committee also recommends an appropriation of fifty dollars to defray the current expenses of the committee.

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### INTRA-PERITONEAL HÆMORRHAGE.\*

BY REGINALD H. FITZ, A. M., M. D.,  
Hersey Professor of Practice, Medical Department  
Harvard University, Boston.

Although having accepted the compliment of an invitation to address your honorable body, I am, nevertheless, impressed with the serious nature of the task. My predecessors have often been men of such distinction in the profession that success was sure to crown their efforts. Such merit as may be lacking on my part I trust may be atoned for by my willingness to make a considerable personal sacrifice to be present at your meeting. A sacrifice that was not

without a sense of pleasure in anticipation, since it was to give me the opportunity of meeting so many eminent physicians in a city which is rapidly coming to the front as one of the most important medical centres of this country.

It might seem fitting that one who has been familiar with the various steps which have preceded the scientific development of medical education in this country during the past twenty-one years might have something to offer on this topic. In almost any other city much might be said which would perhaps serve as criticism, encouragement or stimulation. In Baltimore, however, in the present year of grace, even an enthusiastic advocate of the higher medical education may well hold his peace. It is for your university to establish and

\*Annual Oration delivered before the Medical and  
Surgical Faculty of Maryland, April 27, 1893.



elaborate the model American medical school of the coming generation; as it has been the task of Harvard to faithfully, fearlessly, but always, I hope, judiciously, work toward the same end during the past generation.

In this work, too, we have been obliged to seek for aid from you—our professor of pathology has long been one of your distinguished members, one who has made illustrious the name of your city and State. I can assure you that in the acquisition of Dr. Councilman we feel that a new impetus has been received to add force and breadth to our development. Another of your honored representatives we have gained but to lose. In Professor Howell, our physiological department seemed to have acquired a most important addition to its strength. The lapse of a few months has shown that a wider sphere of usefulness is to be opened to him, and his future labors are to be performed where his earliest distinction has been won.

No greater encouragement can be offered to seekers for progress than to find themselves emulated, even if surpassed, by others whose opportunities may be larger and less restrained.

However high may be the standard of the Johns Hopkins University Medical School, it can be none too high for other schools to strive for. The success of its efforts lies in the hands of such organizations as your honored society and of kindred societies throughout the land.

The practice of medicine is the ultimate aim and object for which all medical schools must provide. However interesting the study of anatomy, physiology and chemistry may be for their own sake, they are but preliminary stu-

dies. They belong legitimately to a preparatory course; not merely to the study of medicine, but to fit the youth to better undertake any professional work, to better pursue mercantile careers, to become better citizens.

They are university studies; and may furnish the best possible training for some individuals to reach the highest success in whatever profession or occupation may be followed. It is the application of anatomy and physiology and chemistry which more exclusively belongs to the medical school. It may be that in our own day of progress these subjects are best taught as sciences where they are most needed for the practical wants of mankind. But chemistry has already become so far-reaching in its industrial possibilities that the merest elements of the science are now required for the immediate needs of the medical practitioner.

It may be questioned whether physiological chemistry is not, strictly speaking, as much of a preparatory study as is general, descriptive and analytical chemistry. Its student need have no aspirations or leanings towards a medical career. He may even find a life's occupation in its pursuit, irrespective of any application of his work to the recognition, prevention or treatment of disease. Pathological chemistry, on the other hand, is of the utmost importance to the physician. Without it his possibilities of recognizing disease, of testing the value of his measures for its relief, may be sadly handicapped. With it there are placed before him far-reaching possibilities in the diagnosis, prevention and treatment of disease, whose scope none of us can define.

The chief end of the vast majority of medical students is to be taught to practice the various branches of medicine and surgery. As the opportunities for development in these directions are offered, the student finds himself more attracted in the one direction than in the other; and his future occupation is the more medical or the more surgical, sometimes against his wishes and despite his control. He is inclined to look upon the treatment of his patient more from the medical or from the surgical point of view, as his opportunities for development have been in the one direction or in the other. This tendency is nowhere more strikingly shown than in the treatment of the diseases of the abdominal cavity. The frequent inefficacy of medical treatment, the immediate benefit often afforded by the surgeon, tend to make the physician less confident of his resources as they make the surgeon bolder in the employment of his methods. The practice of medicine thus tends, in many directions, to become more and more the practice of surgery. But a prevailing tendency is always liable to become extreme and should be guarded against.

In no respect has the progress of abdominal surgery led to more brilliant results than in the treatment of certain varieties of intra-peritoneal hæmorrhage. After the abdomen has been opened the diagnosis is easily made and an existing or threatening hæmorrhage is readily controlled. The surgeon is thus tempted by the success of his exploration in a doubtful case to forget that a surgical operation is a therapeutic necessity, not a diagnostic procedure. He reasons that because persons have sometimes bled to death

when a laparotomy might have saved life, therefore it is necessary to give the patient the chance of having life saved by this operation, although the danger is rather suggested than imminent.

He is not inclined to recognize that the benefit of the doubt may lie rather in the saving of life without an operation. The success of a successful operation is so immediate and positive that it is easy to overlook or disregard the large percentage of recoveries under medical treatment from similar symptoms with all but demonstrable similar lesions. But the finding of a blood-clot after the abdomen has been opened is no necessary justification for the search for it. The tendency to do something when in doubt must always yield to the duty of doing what is most judicious.

It seems, therefore, not unprofitable to consider the subject of intra-peritoneal hæmorrhage from a general point of view, especially bearing in mind the experience of the past, with the hope that the indications for its medical treatment may be made conspicuous and the existence of limitations for its surgical treatment be emphasized.

In requesting your attention to this subject it is not planned to offer any new evidence, but to call to your mind conclusions, which have been previously presented, in such a form as may suggest that differences of opinion still exist as to the best method of treating the class of disease under consideration. To carry out this plan it is necessary to consider the various causes of intraperitoneal hæmorrhage, their symptoms and results.

The prevailing idea that intra-peritoneal hæmorrhage is always a disease of women and is the result of ectopic gesta-

tion has a certain practical value, but is not true. Mild and fatal cases occur in men, though in far less proportions than in women. That the hæmorrhage may take place it is essential that blood-vessels rupture. The rupture demands a weakened vascular wall. This weakening is the result of causes which may occur in either sex alike or may be limited to the female sex.

Obvious causes are the wounds which penetrate the abdominal wall or viscera from without, or which crush or tear the subjacent vessels without signs of external lesion.

The hidden causes are those which demand closer attention. Among these, aneurismal dilatation requires consideration. More common in man than in woman, abdominal aneurisms are usually irremediable. But when they affect the secondary branches of the abdominal aorta, as the smaller omental or mesenteric arteries, the timely treatment of their rupture may save a life otherwise lost.

Fatal intra-peritoneal hæmorrhage is no rare result of the rupture of blood-vessels in malignant tumors of the liver, pancreas and ovaries.

The greatest practical importance, however, is to be attached to the pelvic sources of hæmorrhage. These are to be found almost exclusively in the genital organs of the female. They are the dilated and weakened vessels in the ovaries and broad ligaments, as well as those developed in the course of a tubal or abnormal uterine pregnancy. In this series is to be included the hæmorrhagic pelvic peritonitis, almost invariably limited to women and usually originating from disturbances arising in the genital tract.

Hæmorrhages from scurvy, purpura, hæmophilia, infectious diseases and phosphorus poisoning are without practical importance in the present consideration.

The effects of a rupture of the blood-vessels are, as Veit has conspicuously shown, essentially dependent upon the escape of blood into the open peritoneal cavity or into a part which has been separated from the rest by adhesions. In the former case the blood is poured out without hindrance; more or less rapidly according to the calibre of the ruptured vessel, the size of the opening, the volume of blood and the strength of the heart. The result is a hæmoperitoneum. The liquid and clotted blood lies in the lowermost parts of the abdominal cavity beneath and between the intestines. According to the extent of the hæmorrhage the hæmoperitoneum either proves rapidly fatal or the blood is absorbed, except in occasional instances, without the production of a tumor.

If the hæmorrhage takes place into a part of the peritoneal cavity shut off from the rest by adhesions, a hæmatocele follows. The hæmatocele is usually pelvic in its origin and seat, occurs in the female, and forms a tumor. If the bleeding continues, this tumor enlarges, and may subsequently rupture and produce a hæmoperitoneum. If the bleeding ceases the frequent result is the absorption of the clot. But the hæmatocele is generally seated in the pelvis, a region in which septic infection of the clot may be easy, and the infected clot then causes a destructive inflammation of the surroundings. There are peritonitic adhesions to the walls of the rectum, vagina or bladder; and a septic peritonitis follows, or a dis-



charge of the softened clot takes place into one of the hollow organs above mentioned; oftenest into the rectum, then into the vagina, rarely into the bladder. The discharge into the rectum or vagina if properly controlled is usually harmless and beneficial; while that into the bladder is most serious, from the extension of the resulting cystitis to the kidney, with the production of a pyelonephritis. Perforation may also take place elsewhere into the bowel, with permanent fistulæ, through the hæmatocele, between the ileum or cæcum, into the rectum. Absorption without septic infection may take place, however, and the possibility of the occurrence of the above complications is an insufficient justification for a severe operation for their prevention.

Intra-peritoneal hæmorrhages may thus be divided into those which are immediately or remotely dangerous and those which are comparatively harmless. The immediately dangerous are such in virtue of the rapidly progressing anæmia. The remotely dangerous become so in consequence of the complications which may arise in the subsequent history of the extravasated blood.

In the practical consideration of the individual case it first becomes necessary to establish the existence of an intra-peritoneal hæmorrhage, then to determine its cause and finally to decide upon its treatment. That the diagnosis is not always easy and is sometimes extremely difficult, is obvious to all who have had experience in the matter or who are familiar with the literature of the subject. An exploratory laparotomy has often proven to be the only means by which the diagnosis has been established; and

has also repeatedly made clear that there was no intra-peritoneal hæmorrhage, which had been suspected.

A well person, suddenly seized with rapidly advancing collapse, presenting a pinched, sunken face, an anxious and fearful expression, cold extremities, a clammy skin, deep and sighing respiration, a hollow, husky voice, an almost imperceptible pulse, and without other objective symptoms, is, presumably, suffering from a concealed hæmorrhage. Abdominal or pelvic pain is the only positive localizing symptom, and may not be of extreme severity or of prolonged intensity. Various sources of intra-abdominal hæmorrhage may be excluded—as the stomach, intestines, urinary tract or uterus—by the absence of previous symptoms pointing to disease of these organs, and by the failure of blood to appear in the vomit, stools, urine or vagina. A gastro-intestinal source of so serious a hæmorrhage is usually preceded by long-continued attacks of pain in the region of the stomach or duodenum, or by symptoms of typhoid fever or of fibrous hepatitis. Metrorrhagia sufficient to produce so profound a collapse occurs only with placenta prævia or after child-birth; while renal or vesical hæmorrhage, even when severe, would fail to produce so much immediate disturbance.

The existence of a severe intra-peritoneal hæmorrhage is thus to be established by exclusion. Veit has shown that there are no physical signs sufficient to prove the presence of a large quantity of blood in the free peritoneal cavity. It gives rise to no more dullness than may result from intestinal contents; it offers no more resistance to

the palpating finger than may be offered by coils of intestine.

The treatment of so severe an intra-peritoneal hæmorrhage as that above suggested necessarily depends upon its cause. If it is due to an aneurism of the abdominal aorta, or to a cancer of the liver or pancreas, a laparotomy is useless, except, perhaps, to offer in anæsthesia an easy means of dying. Antecedent symptoms are likely to have given evidence of these lesions and, fortunately, death is often so rapid from these causes that time is lacking even for anæsthesia.

On the contrary, immediate laparotomy is indicated for such severe intra-peritoneal hæmorrhage when an aortic aneurism or a malignant abdominal tumor is to be excluded. The causes are then to be found in a small aneurism or in an ectopic gestation.

The former is rare, of greater frequency in man; the latter common and preceded by symptoms which are often sufficiently suggestive. These are the omitted menses, the irregular metrorrhagia, decidual discharge, paroxysmal or peritonitic pain, and possibly, on vaginal examination, a tumor outside of the uterus with slight enlargement of the latter. The tumor often fails, when much needed for diagnosis, from simultaneous extrusion of the fœtus and escape of blood into the abdominal cavity.

The collapse may be less profound, though still severe, and be independent of hæmorrhage into the peritoneal cavity or into the hollow organs of the abdomen. A ruptured ovarian cyst, or a tumor with a twisted pedicle, may then be concerned. In either case a tumor of sufficient size to be easily recognized will be found. An eventual laparotomy is

then unquestionably demanded; an immediate laparotomy may be extremely injudicious.

The cases presenting the greatest difficulty in diagnosis are those where the question of treatment may best be in dispute. Debility and exhaustion are present; unexpected, perhaps, but not extreme. There is moderate pallor and the pulse is but slightly accelerated or weakened. The abdominal or pelvic pain may be as severe and sudden as before, but the constitutional disturbance is less. Such a patient may walk into the consulting room complaining of little else than pain. In this class of cases there is no considerable hæmorrhage into the free peritoneal cavity, but a circumscribed tumor will be found on pelvic examination. It is the nature of this tumor which demands most careful consideration. It should be determined, if possible, by other means than by an exploratory laparotomy. If this is employed the treatment becomes of necessity abdominal and surgical, whereas in many instances it should be medical, or, if surgical, then vaginal or rectal.

Such cases are almost invariably limited to women. Similar symptoms may occur in man, as in a case recently under my observation in the practice of Dr. Loring, of Newton. They proved to be due to an extensive sub-peritoneal hæmatoma from a ruptured small aneurism of the iliac artery. The pelvic tumor is to be found, at the outset, near the uterus, usually behind or at one side. It is firm, elastic, sensitive and, when early appreciated, may be as large as an orange. Such a tumor may be a pustule, or an ovarian or uterine tumor, but these lack the sudden development

of anæmic symptoms. It may be a retroflexed, pregnant uterus, which is to be eliminated by finding a dilated bladder and a history of urinary retention. The tumor may be due to retained menses or to pregnancy in a rudimentary horn. The tumor then forms a part of the uterus, the os being dilated and crescentic. By way of exclusion, then, the tumor is likely to prove a hæmatocele or a hæmatoma of the broad ligament.

The same causes, viz., ruptured vessels in the ovaries, tubes and broad ligaments are concerned in the origin both of the hæmatoma and the hæmatocele. In addition, the latter may be caused by an antecedent attack of pelvic peritonitis which is likely to be inferred from the previous history of the patient. The usual cause of each is to be found in an ectopic gestion, the important features in the recognition of which have already been stated. The effect upon the fœtus is likely to be the same in either case. The quantity of blood poured out is usually sufficient to destroy the fœtus if it lies between the folds of the broad ligament; and the same result is likely to follow the rupture of the sack in which the fœtus is contained. In either case the hæmorrhage usually takes place outside the fœtal membranes. Compression by the extravasated blood is the probable event in case of the hæmatoma; extrusion of the fœtus, with or without its membranes, is the probable event where the rupture of the maternal enveloping membrane takes place into the peritoneal cavity.

Unfortunately the distinction between the two is not always, perhaps not often, to be determined by physical examination. Yet the best treatment of the

hæmatoma is almost universally recognized to be expectant, that is, medical; while that of the hæmatocele is often in dispute. The important practical point of distinction between intra-peritoneal hæmorrhage with and without a tumor is that delay is possible and desirable in the latter case; dangerous, perhaps fatal, in the former.

The diagnosis of the hæmorrhagic nature of the tumor often becomes confirmed in the course of twenty-four hours by the subsequent symptoms. It is likely to become larger and eventually may even be of the size of a child's head. It fills the pelvis, perhaps projects above it, and presses upon the bladder, rectum or pelvic nerves. Frequent micturition, painful stools, pains or paræsthesiæ in the legs are likely to ensue. The vaginal wall becomes depressed behind or in front. The uterus is elevated, near the symphysis or in the hollow of the sacrum, according to the retro- or antero-uterine seat of the tumor. Symptoms of a mild localized peritonitis now become apparent. There is chilliness and slight fever, the latter lasting but a few days, hypogastric and vaginal tenderness, which may remain for some time longer. The tumor tends to become smaller, denser and in the course of time, may be represented merely by a diffuse induration. The larger the hæmatocele the more prolonged the period of absorption and the greater the liability of the patient to discomfort from the associated adhesions, obliterated tubes, dislocated ovaries and displaced uterus. Dysmenorrhœa, sterility and chronic invalidism are then not unlikely results.

In other cases it becomes increased in size, with recurrence of the acute symp-



toms. The more frequent the recurrence, the graver the condition, the greater the danger of perforation. This may be expected to take place into the rectum when the latter becomes irritable as shown by frequent mucous discharges and tenesmus. Rectal examinations may then reveal a soft spot in the elsewhere hard wall of the tumor indicating the point where the discharge is to take place. In like manner a pointing of the hæmatocele into the vagina may be shown by a yielding, bulging mass on digital examination of this cavity. The evacuation is followed by temporary relief, which may become permanent with the disappearance of the tumor. On the other hand, as before stated, if infection from the rectum or vagina takes place, leading to putrefaction of the clot and gangrene of the wall, symptoms of peritonitis are likely to appear. But the infection of the cavity of the tumor may be rendered harmless after its occurrence or be prevented from taking place without the need of a laparotomy.

In brief, the recognition of a pelvic tumor and the more accurate determination of its nature in connection with the symptoms of intra-peritoneal hæmorrhage is of the greatest importance. Small and large hæmorrhages into the free peritoneal cavity may occur with or without the presence of a tumor. Small hæmorrhages are readily absorbed; large hæmorrhages, without surgical interference, prove fatal in the course of a few hours or days and require immediate laparotomy whether a tumor is present or not.

If the symptoms are less urgent and a large tumor is present, especially if there is no history suggestive of pregnancy

and there is the previous knowledge of a tumor, the laparotomy may be postponed until the patient recovers from the shock due, probably, to the twisting of the pedicle of a uterine or ovarian tumor or to the rupture of a cyst.

If the symptoms are less urgent and a small tumor is present the case will bear watching. The condition is likely to be a hæmatocele or a hæmatoma. In either event there is no urgency unless the hæmorrhage persists, the tumor greatly enlarges or ruptures and a hæmo-peritoneum results, in which case there can be no question of an immediate laparotomy.

Frequently the extravasated blood is likely to be absorbed without serious disturbance. The patient should therefore be treated by ice to the abdomen, rectal or vaginal enemata of cold water and by opiates for the relief of pain. Absolute rest, the use of the catheter and saline laxatives complete the requirements of treatment.

If as stated by Gusserow, the hæmatocele is so large as to be mechanically disturbing or absorption ceases, or the circumstances of the patient do not permit slow absorption, or prolonged rest afterwards, or if the contents become infected as indicated by symptoms of septicæmia, the tumor should be opened, emptied and drained without delay. Whether the incision should be made through the abdominal, vaginal or rectal wall must be determined in the individual case, with a general tendency in favor of vaginal drainage.

The great success which has followed the vaginal incision, the tumor being opened and the clots removed, has been repeated so many times by so many

operators that it is unquestioned. This too, without waiting for any of the possibilities which make the operation demanded. It has often been done in the early history of the tumor, to save time in healing or to obviate possible repeated or continual hæmorrhage. Healing may be even more rapid than after abdominal incision, days only elapsing between the operation and the recovery of the patient. The comparative merits of the various methods of treatment can only be determined after the lapse of time. The older statistics with reference to treatment by purely medical methods or by puncture, even by incision, are no absolute standard of what may be done now, with a better understanding of the etiology of the condition, a surer knowledge of the complications which may arise and a more complete appreciation of their timely prevention. The recommended early abdominal incision is not yet sufficiently proven to be without serious after-effects; in the production of hernia, or in the formation of abscesses which may lead to intestinal obstruction or may act in favor of producing a subsequent intra-peritoneal hæmorrhage, from the same cause, namely, ectopic gestation. That this is no fanciful assumption has been recently illustrated in the practice of my friend, Dr. F. B. Harrington, of Boston, who has twice operated upon the same woman for intra-peritoneal hæmorrhage from ectopic gestation within a period of two or three years.

The comparative results of other treatment than laparotomy as shown by Zweifel a few years ago are as follows:

Of 144 cases treated expectantly, 16.6 per cent. were fatal; 66 cases treated by puncture, 15.1 per cent. were fatal; 30

cases treated by vaginal incision, 10 per cent. were fatal.

The medical treatment of intra-peritoneal hæmorrhage, when feasible, permits the patient to recover without operation and renders possible and easy operation when necessary, and one not demanding especial skill.

Laparotomy for intra-peritoneal hæmorrhage is unnecessary in a large number of cases and when undertaken substitutes a severe for a simple operation, and one requiring considerable technical skill, therefore not generally applicable.

In bringing these remarks to a conclusion, I must apologize for my shortcomings in presenting to you rather a medical essay than an address or oration. The last term would have been so discouraging that I should have declined the attempt had I known it was to appear under this term. Professor Welch, in extending me your invitation, allowed me the usual license of selecting my subject. I trust I may have interested you in the practical side of the question, even if I have presented it under the false colors of a dignified title.

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The Texas Legislature, now in session, has passed an act making it a penal offense in a physician to give a prescription for whiskey without an examination.—*Courier-Record*.

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First Boy: "No, sir, you don't catch me shamming off sick to stay home from school and get dosed up with castor oil and such stuff." Second Boy: "Oh, I'm all right on that. We're homœopaths at our house."—*Life*.



## CALOMEL.\*

BY DR. EDWARD ANDERSON,  
OF ROCKVILLE, MD.

Mr. President and Gentlemen of the Medical and Chirurgical Faculty of Maryland:—I feel proud of the privilege of addressing this time-honored society, of which my grandfather was one of the incorporators. Men have been the same in all ages, but customs have changed. We are moving in circles, as it were, and as often leaving a truth as approaching one.

The establishment of laboratories and teaching of the germ theory will tend more strongly to fix the truth in the minds of men than anything that has heretofore been attempted.

I have chosen as my subject "Calomel," styled by one of the most distinguished medical men in America, "The Samson of the Materia Medica." I will first speak of its local application, but will preface my remarks by again referring to Bartholomew Parr's London Dictionary, under the head of essentials, wherein he says, "Calomel mixed with starch and strewn on a pledget of lint is perhaps the best application to the stump of an amputated limb." When calomel comes in contact with the fluids of the body, it is converted into corrosive sublimate, and Parr's application for a wound was no more nor less than a dry dressing of the bichloride of mercury. If this mode of dressing wounds had not been lost sight of, thousands of lives would have been spared. That it was lost sight of is not to be wondered at when we remember that the ligature was abandoned for centuries. Calomel mixed as before mentioned is the best application for a

slow healing ulcer and chafed surfaces; calomel may be applied in any amount to the unbroken skin, but we should be exceedingly careful in applying it on a raw surface, for when so used it is one of the most active of mercurials. When the epidermis has been removed over a large area, not more than twenty grains to the ounce of starch should be used, and particularly should this rule be enjoined when treating elderly persons or those suffering from disease of the kidneys, through which organs calomel is largely eliminated. In the aged, the action of the kidneys is apt to be impaired when no disease of those organs can be discovered; I have known of two deaths, the result of the administration of calomel in elderly persons—one from its external and the other from its internal administration; children bear the use of calomel exceedingly well, and the reason often given is, that the salivary glands are imperfectly developed; but I think it is because their kidneys and bowels respond readily to its influence. In the treatment of eczema, rhus poisoning and the itch, calomel mixed with lard, in the proportion of a drachm to the ounce, is the best application with which I am acquainted, and under such circumstances it may be used in any amount, and for any length of time. The best treatment for boils is to slash them when they are small and rub dry calomel into them. Typhoid fever patients are sometimes afflicted with furuncles, and this treatment will enable them to assume any position they think proper in a short time, which is a very important consideration.

When I began the practice of medicine, calomel was very unpopular. I have used it more and more frequently

\*Read before the Medical and Chirurgical Faculty of Maryland, April 27, 1893.



since, and my success has been in proportion to the frequency of its use. I use it in all cases of congestion where the bowels are not too lax, and often, even then, accompanied with opium. In chronic diarrhœa nothing else is equal, in my opinion, to one and a half grains each of calomel and extract of opium with eight grains of ipecac, made into twenty pills, one pill given three times daily. Calomel will never salivate whilst the bowels are open; they should never be allowed to remain locked more than twenty-four hours after its administration.

Some claim that calomel will abort an attack of typhoid fever, but I think that is claiming too much for it. It should never be withheld in the beginning of the disease, as it relieves congestion, particularly of the brain, and lessens the shock to the nervous system which often causes a fatal termination. As in all germ diseases, this medicine would no doubt be useful throughout its entire course, but the ulcerated condition of the bowels precludes the use of anything that would increase the peristaltic action.

If there is a specific in epidemic influenza, it is calomel. I will say nothing about its exhibition in syphilis, for experience teaches me that in that disease mercury should be employed in no other way than by inunction, and as calomel is insoluble, it cannot be so employed.

Calomel plays its most important role as a diuretic, and is the most certain and speedy one we possess. Some years since, a man who was about to die from dropsy, the result of heart disease, sent for me after having been treated by regular practitioners and homœopaths; they had exhausted nearly all the

known diuretics upon him without much benefit. I managed to keep him alive and he was enabled to drive around the country and enjoy himself for nearly a year, with the old familiar prescription of one grain of calomel, squills and digitalis each, made into a pill—one given three times daily.

Last fall a child in Rockville was under the care of three homœopathic physicians; he was suffering from rheumatic pericarditis and endocarditis. They gave him up and said he had only a few hours to live. The verdict might have done very well and been accepted, but one of the doctors went so far as to ask for the child's heart. This was more than the father could bear, and consequently I was called upon and almost forced to take charge of the case. After relieving the child's great distress for a time with suitable remedies, general dropsy set in, accompanied by enlargement of the liver, that organ reaching as low as the umbilicus. At this stage of the disease a prominent physician was called in consultation, who was once President of the American Medical Association; he said that the child might get up again if the heart lesion was all, but with the condition of his other organs, particularly the liver, he could never get out of bed. I asked him what he thought of calomel? He said if a purgative had to be given, calomel would be the best one to use. Edema of the lungs was the most urgent symptom and called for immediate relief; his legs became so much distended that I had to puncture them every few days to keep them from bursting; I had also to circumcise him, in order to enable the urine to escape. The fluid in the lungs kept him cough-

ing continuously, and was fast bringing his life to a close, when I commenced giving him calomel in tenth-grain doses, every four hours, and kept up this treatment for three months, with the effect of removing all the surplus water except a little in the peritoneal cavity. There is still no click on closure of the valves of the heart, but the child is running about the streets and enjoying himself with the other children of the town.

In pneumonia, calomel is thought to act beneficially; it is supposed to do so by preventing the deposit of fibrin. It may act that way, but I employ it in this disease as a diuretic. In treating grown persons, I give every four hours one-fourth of a grain of calomel with one grain of quinine, and as much Dovers' powder as is required to prevent too free action of the mercury upon the bowels. When I neglect to employ calomel in this way for infants and delicate adults, there is an accumulation of fluid in the lungs and bronchial tubes, which they are unable to get rid of, and they die in consequence of it, in about seven days, through failure of the air to enter the lungs, and death results as in laryngeal diphtheria. While on the subject of calomel as a germicide and antiseptic, I forgot to mention its employment in diphtheria. The physician who has the reputation of having been the most successful in this State, in the treatment of this disease, told me that in the beginning he always gave a full dose of calomel. In my only successful case of laryngeal diphtheria, I gave half a grain of calomel every four hours until relief was obtained. I, of course, employed steam by inhalation at the same time. The patient was six years old.

Now, gentlemen, I hope you will excuse these disjointed remarks. If you had been on our roads with me for the last few months, your only surprise would be that I am not disjointed as well as my remarks.

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### Society Reports.

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#### BALTIMORE MEDICAL ASSOCIATION.

MEETING HELD MAY 8, 1893.

Dr. J. I. Pennington, President, in the chair.

*Dr. J. H. Branham* reported a case of EXTENSIVE ULCER OF THE LEG, treated at Bay View last October. The ulcer occurred on the right leg of a colored woman also suffering with diabetes. She was the mother of several children. The sore extended around the front of the leg, almost meeting on the posterior surface. Skin-grafting was tried. Thorough antiseptics was observed. The granulation tissue was excised as completely as possible and three large flaps were stitched in. They united absolutely. The ulceration had existed for ten years. Dr. Branham attributes much of the success to the antiseptics.

*Dr. Branham* also related the history of a case of HIP-JOINT DISEASE. Last August he was called to see a child seven or eight months old that had had a fall from its carriage. The family history was good. When he saw it, it was in convulsions, which were treated in the usual way. There was also a swelling of the arm not involving the elbow-joint. This was poulticed. An abscess was opened which refilled and was again lanced. His attention was also called to



some trouble about the hip-joint which resulted in an abscess. The head of the femur became absorbed. The abscess was opened and the cavity was washed out and drained. A rubber tube was kept in for two months. The wound healed readily. The features in this case are the youth of the child, the formation of a false joint and the fact that the child has nearly complete extension. *Ætiology:* the fall causing abscesses in right arm and right hip. Amount of movement in hip remarkable. Considerable shortening, about one inch.

*Dr. Chas. H. Jones* asked how long after the fall it was before convulsions set in. About a week. *Dr. John D. Blake* asked how long after the fall it was before the hip-joint trouble commenced. *Dr. Branham* said that it was noticed about two days after the convulsions and the abscess in the right arm. *Dr. Blake* thought that the trouble about the hip-joint must have antedated the fall. Consequently, some other cause than the fall must be looked for.

*Dr. Branham* did not agree with *Dr. Blake*. The process was very acute. The operation for hip-joint disease was performed about two weeks after the fall, sufficient time having elapsed to destroy the head of a soft bone in a young infant. The operation, the antisepsis, and the drainage probably saved the life of the child. It will probably walk in a short time with a thick-soled shoe.

*Dr. Branham* also related a case of tubercular trouble in the hip of a colored girl. There were numerous openings on the thigh and much burrowing of pus. Hip-joint amputation was performed; Esmarch's bandage was used; and the operation (a modified form of *Furneaux*

*Jordan's*) was bloodless. The operation was somewhat prolonged on account of the head of the femur being comparatively healthy, the disease being in the shaft of the bone. Patient did well that night, but there was a considerable rise of temperature next day. Death occurred 24 hours after the operation. There was no collection of pus or fluid.

*Dr. S. T. Earle* stated that the Examining Board is anxious to have the law in regard to practice carried out and asked the co-operation of the medical societies, wishing to know of any violation of the law and promising that no unpleasant consequences should ensue to the informer.

*Dr. Blake* thought that it would be better for some one to consent to a friendly litigation.

*Dr. John Neff* asked if the examination was not required only in the case of persons commencing practice after the passage of the law.

*Dr. Earle* did not quite agree with *Dr. Blake's* suggestion.

EUGENE L. CRUTCHFIELD, M. D.,  
Sec'y.

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According to the *N. Y. Med. Examiner* the Provident Bounty Association of London has started a new form of insurance, that is against too rapid increase in a family. When an addition is expected in a family the father deposits £5 and so becomes a policy holder. Should his wife present him with twins he gets £50, and for triplets £75. The company has a large capital and the directors are well-known and influential business men.—*Montreal Med. Jour.*



## MARYLAND MEDICAL JOURNAL,

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A. K. BOND, M. D., Editor.

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BALTIMORE, JUNE 17, 1893.

### Editorial.

#### OUR SANITARIUMS FOR CHILDREN.

Much is being done by the citizens of Baltimore to secure for the children of her small streets and alleys an opportunity to enjoy the cool air and refreshing scenery of the country during the hot season. Yet there always seems to be a demand in excess of the supply of summer outings.

The various institutions of this sort for the care of city children are now open for the season. Some are for the sick; some limited to the healthy. Among those of the former class are the Garrett Free Sanitarium for Children, and the Wilson Sanitarium.

The Garrett Sanitarium was established and is maintained by Mrs. Robert Garrett. It is located at Mount Airy on the Baltimore and Ohio Railroad. It receives children under twelve years of age who are sick of non-contagious diseases or in

need of surgical treatment. It is well equipped and has a staff of competent physicians (one of them resident at the sanitarium) and trained nurses. Children are admitted upon application in person at the Garrett Free Dispensary, 27 North Carey St., any week-day except Wednesday, between 12 and 1 o'clock. Parents may accompany their children to Mount Airy and may visit them once a week, on Tuesdays. Railroad tickets are furnished free of charge.

The Wilson Sanitarium is situated on the Western Maryland Railroad, and is open during the summer for sick infants, especially those with summer diarrhœas. We have frequently had occasion to note the excellent work done here in the service of these poor children.

The Country Home for children is located at Orange Grove station on the Baltimore and Ohio Railroad. It is designed to afford here a pleasant outing for little boys and girls, of two consecutive weeks during the hot season. The children must be free from contagious disease and active enough to get about by themselves. A fine new building has been erected, with airy dormitories, wide porches, bath rooms, chapel and a play room for use in wet weather.

The editor will be glad to direct physicians at any time to the officials through whom admission to these sanitariums is to be obtained; or to give any desired information in regard to the location, sanitary condition, etc., of the institutions.

#### THE CHILDREN'S FRESH AIR SOCIETY.

We are pleased to learn that the admirable work of this society is about to

begin for the summer. As we have explained before in these columns, the society sends boys and girls, able to look after themselves, to homes thrown open to them without charge by farmers and other kind-hearted persons, who are willing to take one or two boys or girls into their families, and give them a few weeks of real country life in the hot season.

This is, we believe, the very cheapest device yet hit upon for giving a summer outing to the boys and girls of the alleys and small streets of the city, yet it is in many respects the most satisfactory way of all, having a flavor of individual, personal kindness to the children which is somewhat obscured in the large sanitariums.

The relations between the children and their country hosts have so far been very pleasant; many of the latter expressing deep regret at the departure of their little guests.

All children are examined by physicians, before they are sent out, to see that they have no contagious disease.

As the good work of the society depends for its extent upon offers of country families to take the children, we would urge our readers to make the work as widely known as possible among their friends and patients.

The address of the secretary who has the work in charge is Mr. Wm. L. Smith, 920 McCulloh St., Baltimore. Any communications sent care of the editor of this JOURNAL will be duly forwarded to Mr. Smith.

#### THE NEW FRENCH MEDICAL LAW.

A friend has sent us a clipping descriptive of the requirements of this

law, which concerns all travelers in France.

It appears to be in substance the same as the law now adopted by many of the cities and country districts of England, in accordance with which physicians are required under heavy penalty to report cases of infectious disease coming under their charge. The list of notifiable diseases is to be established by the Academy of Medicine in conjunction with the Public Hygiene Commission.

Notification of infectious diseases is certainly a desirable thing in every well conducted community. In Baltimore the law requires both the physician and householder to notify. At present it appears to lead in most cases simply to an entry of the notification on the books of the Health Office. With the present inspecting force enjoyed by Baltimore this is all that ought to be done.

The trouble in France is that there seems to be a great scarcity of infectious hospitals to which foreigners can be taken. If inspectorial visits follow notification, the publicity given to infectious cases will be greater, and boarding-houses and hotels will be more prompt and certain to turn the patient out of doors. Where they are to find refuge in such an emergency is the problem.

In the already over-crowded hospitals they must fall under the charge of doctors and nurses unacquainted with their language and needs. Moreover, the class of Americans and others who travel abroad will not willingly seek the public hospital.

Private hospitals which would admit strangers sick with infectious diseases are few in number, expensive, and in some cases restricted to the reception of

persons of specified nationality or religious faith.

The correspondent of the Paris edition of the *Herald*, writing from Nice, pleads for the establishment in that city, which every year receives thousands of tourists, of a cottage sanitarium for the reception of sick foreigners, especially those ill with infectious diseases, where patients could be attended by physicians of their own choice—of their own nationality, if possible.

The plea is a timely one, and deserves the attention of all travelers.

### Reviews, Books and Pamphlets.

*A Practical Treatise on Materia Medica and Therapeutics*, with Especial Reference to the Clinical Application of Drugs. By John V. Shoemaker, A. M., M. D., Professor of Materia Medica, Pharmacology, Therapeutics and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia; Physician to the Medico-Chirurgical Hospital; Member of the American Medical Association, of the Pennsylvania and Minnesota State Medical Societies, the American Academy of Medicine, the British Medical Association; Fellow of the Medical Society of London, etc., etc. Second edition, revised. In two royal octavo volumes. Volume I, 353 pages: Devoted to Pharmacy, General Pharmacology, and Therapeutics and Remedial Agents not Properly Classed with Drugs. Volume II, 680 pages: An Independent Volume upon Drugs. Volume I, in cloth, \$2.50 net; sheep,

\$3.25 net. Volume II, in cloth, \$3.50 net; sheep, \$4.50, net. Philadelphia: The F. A. Davis Company, Publishers, 1914 and 1916 Cherry Street.

A very complete and practical treatise on *Materia Medica* and *Therapeutics*, in which the author condenses nicely the best experiences from old standby remedies as well as the latest and newest contributions to our drug list. He has aimed well to make his work a complete repertory of the various means at our command for resisting the ravages or removing the effects of disease.

*International Clinics*; A quarterly of Clinical Lectures on Medicine, Surgery and the allied specialties by Professors and Lecturers in the Leading Medical Colleges of the United States, Great Britain and Canada. Edited by J. M. KEATING, now of Colorado Springs; JUDSON DALAND, M.D., Philadelphia; J. MITCHELL BRUCE, M. D., F. R. C. P., London, England; and D. W. FINLAY, F.R.C.P., Aberdeen, Scotland. Volume I, 3d Series. Philadelphia, 1893: J. B. Lippincott Co.

The scope of this series of clinical disquisitions by eminent practitioners is sufficiently explained in the title page and in our previous notices. We find the volume before us a storehouse of useful knowledge on medical subjects wherein the reader may obtain numerous practical hints for daily use. Many of the lectures of course simply present, with personal emphasis, old facts in condensed form. Others offer new and original thoughts and observations. Among the latter may be noticed the lecture by Dr. J. Bland Sutton on amputation of the upper limb for lym-



phatic œdema secondary to cancer of the breast; and a therapeutic study by Dr. Charles G. Stockton on the uses of chloride of gold and sodium.

We gladly recommend the volume and the series to the attention of our readers.

*Annual Report of the Health Department to the Mayor and City Council of Baltimore for the Fiscal Year Ending December 31, 1892.* Baltimore: John Cox, City Printer, 1893.

We note with pleasure the increase in the force of vaccine physicians, which has been followed by an improvement in its protective work.

While not expecting the highest work from any American Health Office run on political lines, we congratulate our health force on its steady advance in sanitary undertakings for the good of the city.

The urgent need for a morgue is shown by the excessive demands made upon that recently established. The renewed plea of the Health Officer for a disinfecting station has since been favorably met. The much-needed Infectious Hospital has at last been provided for, the city council passing an ordinance offered for its establishment, after an amendment had been made eliminating all non-political elements from the board charged with its foundation. It is a pity that practical politics could not have been subordinated a little to the needs of medical science and suffering humanity.

### Medical Progress.

#### "PENDULUM" UVULA.

In the *Medical Bulletin*, May, Dr. Berens, reviewing the records of three

thousand throat examinations, in which eighty-four cases of uvula anomaly were found, says: Of the eighty-four cases, one consisted of what can only be described as a pendulum anomaly; that is, there was from the tip of the uvula a shred of tissue about three lines in thickness, cylindrical in character, one and a half inches long, to the end of which, in turn, was attached a circular mass of tissue covered with mucous membrane, three-eighths of an inch long, five-sixteenths of an inch wide, and one-sixteenth of an inch thick. These conditions were found in a young woman, 19 years of age, who was sent to me as suffering from phthisis. On close questioning, I found that the patient had an excellent family history, but had suffered as long as she could remember from a dry, hacking cough, which was aggravated by certain positions of the head. She was haggard, listless, and about twenty-five pounds under her weight for her height, with an exceedingly capricious appetite, and complaining particularly of sleep disturbed by cough. On examining the fauces, as luck would have it, the cough was excited, and this little pendulum flew forward and lay on the tongue for a moment, to be drawn back with the next inspiration, when it dropped behind the epiglottis and became invisible. However, its presence was easily established by passing the probe around and behind the uvula and drawing forward the long shred, with its expanded tissue. The uvula itself appeared not too long. The little shred was cut off; the patient was put upon tonic treatment, with local applications of sanguinarine and menthol in oil. After two weeks the patient reported that her

cough had ceased, appetite improved, sleep was quiet and refreshing, and that she felt very much better. As the pharynx appeared normal, she was advised to discontinue the use of local applications.

At the end of six months the patient was thirty-five pounds heavier; had become a big, strapping woman, in the enjoyment of the most robust health.

#### CHRONIC MAMMARY TUMOR BECOMING MALIGNANT.

In the *Lancet*, April 29th, Dr. Bennett, of St. George's Hospital, London, writes upon the need for excision of even apparently innocent tumors of the breast and gives in illustration three cases, one of which we quote:

The patient was a lady forty-three years old, who seven years ago discovered quite by accident a small "lump" in the right breast. Having thus discovered it, she, as is the custom with many patients, carefully at first concealed the fact of its existence. No increase of size or discomfort occurred, but ultimately she consulted a physician, who told her that the swelling was not in itself serious, but that, on the whole, it would be better at some convenient time to have it removed, and, further, that if it showed the least inclination to increase removal should at once be undertaken. She did nothing more in the matter till three years later, when she was confined of a child. The swelling then became sensitive and she consulted the accoucheur in attendance, who advised her to leave the tumor entirely alone, unless it grew larger. This advice she readily took. Three years afterwards the increase in size commenced, and still reluctant to have anything done, she allowed the growth to continue until

a fortnight before I operated, when she consulted the physician to whom she originally went and was told to submit to operation without delay. Upon removing the tumor, which lay in a well-marked capsule and was attached to the breast at one point only, I found it was clearly an adeno-fibroma, but in its centre was a rounded mass of softish material to which the increase in size had been manifestly due. This semi-gelatinous material proved to be a "spindle celled" sarcoma and was on all sides surrounded by a layer of tissue identical in structure with that of a benign adeno-fibroma. At one point the sarcoma was creeping towards the surface, and over this part the benign structure was so thin as to be hardly perceptible. The breast around showed no actual sign of disease, but as it was somewhat hard, and as a small hard gland could be felt in the axilla, I thought it better to take away the whole mamma. In this case I think there cannot be any doubt that the tumor had only recently become sarcomatous. The chronic mammary tumor, in fact, represented a weak point in the breast, and irritation of some kind, produced probably during the time of suckling, affected the nutrition of the tumor in such a way that it began to grow erratically, a sarcomatous change in it being the result. If the patient had not been the subject of a chronic mammary tumor it is in my opinion nearly certain that she would not have developed any malignant growth, for this disease as clearly as possible originated in the tumor. I also believe that had the tumor been removed when it was first discovered—that is to say, before the existence of any tendency to change in it



—the patient would not have suffered from sarcoma at all. There is a tradition which is still fostered by the teaching of some of the text-books that these chronic mammary tumors (adenoma and adeno-fibroma) tend to shrink and sometimes entirely disappear during lactation. I do not know upon what evidence this teaching is based; I have seen a great deal of this class of mammary tumor before, during and after lactation, and I can with all truth say that I have never seen a tumor which I had good reasons for believing to be an adenoma or adeno-fibroma show the least inclination to shrink, to say nothing of disappearing altogether. I have, however, seen such tumors increase rapidly during the suckling period, and I have seen, without doubt, a simple adenoma-fibroma become malignant under similar circumstances. Chronic mammary *indurations* sometimes shrink and disappear during lactation, especially after the first parturition, but I do not believe that the true chronic mammary tumor ever disappears in this way, nor can I regard it as pathologically likely that it would do so, as the tendency after irritation would surely be towards growth rather than shrinkage.

#### THE CENTRE OF SIGHT.

In commenting upon the new work of Henschen, of Upsala, on Brain Pathology, the *Ophthalmic Review*, May, says:

A review of all cases in which the lesion involved the cortex alone, or at most in some cases the cortex with the immediate sub-cortical substance, of the whole of the mesial surface of the occipital lobe, shows that in all those cases hemianopsia was present. Hence the centre for sight is on the mesial surface of the occipital lobe.

Cases of partial lesion of the cortex of this surface divide themselves into those accompanied by hemianopsia, and those without that symptom. In the former group are included all those cases where the calcarine fissure was involved in the lesion; while in the latter group the cortex either of the cuneus or of the lingual lobe, or of both of these localities, was diseased, but the calcarine fissure remained normal. The author reports a case of his own, that of a patient named Nils Holm, which will probably become classical as affording definite proof of the situation of the visual centre in the calcarine fissure.

The only symptom in this case was left homonymus hemianopsia, and the only lesion in the brain was a softening which occupied the cortex of the right calcarine fissure, commencing seven millimetres from its posterior end, and extending a few millimetres upwards on the cuneus and downwards on the lingual lobe. The softening extended forwards, too, into the hippocampal fissure, but an analysis of other cases proves that this fissure has nothing to do with vision.

The author believes, moreover, that the evidence he offers, for which the reader must be referred to the original, indicates that the upper lip of the fissure represents the upper retinal quadrants, and the lower lip the lower retinal quadrants. The macular centre, as well as the centre for the periphery of the retina, is in this same fissure, but its exact position he cannot yet determine. He does not think it lies towards the posterior end of the fissure.

The movement for endowment of the University of Maryland Medical School is progressing favorably.



### Medical Items.

The wife: There is a prescription that the doctor left for you to-day when he called and found you out.

The husband: How did he know what to give me?

The wife: He said that from my appearance and symptoms he knew you were suffering from chronic dyspepsia.  
—*Bulletin of Pharmacy.*

Reclus treats anal abscesses as fistulas. Having opened the abscess, he introduces a channeled sound, to the highest point of the cavity, perforates the rectal mucosa, and brings the sound out at the anus, the tissues being then cut through. Since it is necessary to produce a fistula, the abscess should be treated as a fistula at once.—*Canada Medical Record.*

Simple as the operation may seem, there is a way to clean windows and a way not to clean them. The following suggestions may be of use to some, as they save both time and labor. Choose a time when the sun does not shine on the window; else it will be dry-streaked, and no amount of rubbing can prevent it. Brush off all the dust inside and out, and clean woodwork around glass, first. Use for this warm water and ammonia. Do not use soap. Wipe dry with cotton cloth. Do not use linen, as it leaves lint on the glass when dry. Polish with tissue or old newspaper.—*Bulletin of Pharmacy.*

When you see a man *rushing* frantically around in his drug store raising Cain with everybody about everything

and nothing, and on the streets blowing his horn into the ears of the community about his business, and tackling every fellow he meets to trade with him, or jumping astride of him because he don't, that man is said to be "rushing his business." In nine cases of ten one of two things is true. He is either a bundle of nerves strung together on a skeleton, who must go or die, or he has let his business run away with him and he is running to keep out of its road.—*Jour. Arkansas Medical Society.*

Poulticing the ear may seem to be a simple operation, but there is nevertheless a right and wrong way of doing it, and it appears that the wrong way is the one usually adopted. Dr. Buck says that while heat is one of the best remedies in painful inflammations of the middle ear, and the poultice is one of the best methods of applying heat, as usually put on the poultice has little effect. What should be done, he says, is first to fill the external auditory canal with lukewarm water, the head resting on the unaffected side upon the pillow. Then a large flaxseed poultice is applied over the ear as hot as it can be borne. The column of water is thus kept warm and acts as a conductor of heat between the poultice and the inflamed surface.—*N. Y. Med. Times.*

Among 144 obstetric cases by F. Ahlfield at Marburger Clinic between December, 1880, to April, 1892, the author observed 14 cases of rash resembling scarlet fever or measles occurring during the puerperium. In one case it attacked a patient who had undergone abdominal section. The rash was present in two cases on the 2d, 3d and 4th day

after delivery; once on the 5th, 6th, 7th and 8th day. It appeared twice as late as the 10th day and once on the 15th day.

The time of eruption and fever corresponded to the usual appearance of puerperal affections. In several cases other puerperal symptoms were noticed immediately after the appearance of the rash. The author, however, regarded it more as a complication than a sequence.

He concludes that these questionable cases have nothing, or little, to do with scarlet fever or measles proper, and is re-inforced in this belief by Mannkopff, who failed to trace it back to any source of infection; and further, that no others were attacked by the same disease.

The author concludes then to place these under the head of septic exanthemata, believing that it is due to a peculiar poisonous product, and asks the question, why should not, among the numerous micro-organisms which are found in the lochia, certain ptomaines be present, which would have peculiar property of producing these exanthemata?—*Ztschr. f. Gebutsh. u. Gynal.—Med. and Surg. Reporter.*

The Nineteenth Annual Meeting of the Mississippi Valley Medical Association will occur in Indianapolis, Wednesday, Thursday and Friday, October 4, 5 and 6, 1893. A general session will be held each morning and the afternoons will be devoted to section work. There will be three sections at this meeting, viz.: One on General Medicine, one on General Surgery and one on Obstetrics and Gynæcology; the last mentioned having been added since the last meeting. The indications at present are, that for genuine scientific work, this

will be one of the best meetings in the history of the association. The attendance will probably be unusually large, as many physicians expect to make their visit to the World's Fair at this time. Chicago is but a few hours' ride from Indianapolis, and there is no more delightful time of the year in which to visit the World's Fair than this. Holders of tickets to Chicago on any line passing through Indianapolis will be entitled to stop-over privileges at the latter point. Cheap rates will prevail between these two cities. The profession of Indianapolis is united in extending a cordial invitation to physicians and their families to attend the meeting. Reduced railroad rates will be provided, further notice of which will be given. The secretary will be glad to receive titles from those physicians desiring to favor the Association with papers. It is especially requested that these titles be sent as early as possible, in order to give ample opportunity for the appointment of leaders in discussion. The secretary will take pleasure in giving any information in connection with the meeting. Frederick C. Woodburn, Secretary, No. 399 College Avenue.

The following clippings from the address of Dr. Stewart (*Canada Med. Rec.*, April) are found among many other paragraphs worthy of attention:

Be always neat and tidy. People do not like an untidy doctor. And always act the gentleman. Am I going too far when I say it will be to your advantage to be total abstainers? I think not. You will be physically, mentally and morally better. If at the commencement of your career you are thought to be a drinking man, mark my words, it will act as a

brake to your success, and it will very materially interfere with your progress. Nor is this mere sentiment. Many a young man, whose bark like yours has started out with flying colors, has been sadly wrecked on the rock of intemperance, and his life has been to him and to his friends worse than a failure.

If you would succeed as a family practitioner you must have the mother on your side; if you have not the full confidence of the mother you will be sadly handicapped. She cares not whether you can diagnose a tumor in the motor area of the brain or remove a kidney. She wants a man who can tell her how to make a poultice and how to arrange all the little details of the sick room. She wants a physician who is affable and pleasant; a physician who will patiently listen to her as she relates in her own way all the real and fancied ills of her baby; a physician who can give that undivided attention as if her baby was the sole and only baby in the world. She wants someone whom her children will love and respect. The man who has these qualities with a fair amount of professional ability will often succeed when perhaps a more learned confrère may be left behind.

The period of infectiousness of contagious diseases, according to the State Health Board of Pennsylvania, is:

Small-Pox—Six weeks from the commencement of the disease, if every scab has fallen off.

Chicken-Pox—Three weeks from the commencement of the disease, if every scab has fallen off.

Scarlet-Fever—Six weeks from the commencement of the disease, if the peel-

ing has ceased and there is no sore nose.

Diphtheria—Six weeks from the commencement of the disease, if sore throat and other signs of the disease have disappeared.

Measles—Three weeks from the commencement of the disease, if all rash and the cough has ceased.

Mumps—Three weeks from the commencement of the disease if all swelling has subsided.

Typhus—Four weeks from the commencement of the disease, if strength is re-established.

Typhoid—Six weeks from the commencement of the disease, if strength is re-established.

Whooping Cough—Six weeks from the commencement of the disease, if all cough has ceased.

Under judicious treatment the period of infectiousness may be considerably shortened, but *no child suffering as above should be admitted to any school after a shorter period of absence, and then should be provided with a medical certificate*, that he or she is not liable to communicate the disease.

Length of Quarantine.—Teachers or children *who have been exposed* to infection from any of the following diseases may safely be re-admitted to the school, if they remain in good health (and have taken proper means for disinfection) after the following periods of quarantine:

Diphtheria, 12 days; scarlet fever, 14 days; small-pox, 18 days; measles, 18 days; chicken-pox, 18 days; mumps, 24 days; whooping-cough, 21 days.

Adults may be re-admitted immediately, if they disinfect their clothes and persons.—*Ex.*



# MARYLAND MEDICAL JOURNAL.

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### Original Articles.

#### SUPPURATIVE INFLAMMATIONS WITHIN THE TEMPORAL BONE.\*

BY HERBERT HARLAN, A. M., M. D.,  
Professor of Ophthalmology and Otolaryngology, Baltimore  
University School of Medicine; Surgeon to the  
Presbyterian Eye, Ear and Throat Charity  
Hospital.

That part of the human anatomy known as the petrous portion of the temporal bone, while it is chiefly given up to the organ of hearing, contains besides, or is in immediate proximity to, many other things of so great importance in the consideration of the present subject, that I may be pardoned if I recall to your minds as briefly as possible a few of them and their relative positions to the starting point of nearly all the suppurat-

ing inflammations of the temporal bone, namely, the middle ear.

The tympanic cavity is divided into two portions. The atrium, that portion situated opposite the drum membrane, and in the direct line of vision through the external auditory meatus; and the attic, generally a smaller cavity continuous with the atrium, but above it and out of direct view. This latter cavity is of much greater interest to the aurist and the pathologist, the chain of ossicles traversing it and separating it into two portions. In the front opens the eustachian tube, and backwards and outwards are the large and free openings to the mastoid cells. I desire in this place only to remind you further that the roof of the tympanum lies in contact with the meninges of the brain, so that in caries of this wall the patient may die of purulent meningitis or cerebritis. Again,

\*Read before the Medical and Chirurgical Faculty of Maryland, April 27, 1893.

caries of the lower wall may be followed by phlebitis of the jugular vein, while caries of the inner wall has sometimes, according to Roosa, caused destruction of the coats of the carotid artery and fatal hæmorrhage; also a suppurative inflammation of the labyrinth, with extension into the cavity of the skull. The mastoid cells are separated from the lateral sinus by a thin plate of bone only.

As I have said above, nearly all suppurative diseases of the temporal bone have their origin in the middle ear, and the comparative frequency of middle ear suppuration to all other diseases of the ear is shown by Bezold in an analysis of 11,654 cases to be 29 per cent. Burkner, in an analysis of 43,730 cases taken from sixteen different authors, makes the percentage exactly the same. At the Presbyterian Eye, Ear and Throat Charity Hospital of this city, I and my colleagues have treated in the fifteen years of its existence 17,562 cases of ear disease. In that number there have been 2,692 cases of acute suppurative otitis media, and 3,298 of chronic suppurative otitis media, making a total of 5,890 middle ear suppurations, and giving a percentage of 29.9. This makes it very clear that the title of this paper embraces nearly one third of all diseases of the ear.

That suppurative disease of the temporal bone is very common, every medical man of experience must be aware, but that a correct notion as to its dangers and its relative mortality to that of other diseases is entertained by the bulk of the profession or the public, I very much doubt. Some are inclined altogether to underrate the seriousness

of suppuration of the ear, while others are equally prone to exaggerate its dangers. As a matter of fact it is very difficult to get at any reliable statistics bearing on this point. Barker, by reference to the Registrar-General's reports for England, shows that about 400 deaths during the ten years, from 1878-1888, are annually set down to what is vaguely termed "*otorrhœa*" or "*otitis*" in the official reports and goes on to say that this only gives us a faint shadow of the truth, and claims that at least four or five times that number of deaths have suppurative otitis as the primary cause.

I have gone over the reports of our Health Department from 1872 to 1892, twenty-one years, and tabulated the deaths attributed to brain abscess, brain inflammation, meningitis, otitis and *otorrhœa*. Up to 1875 everything seems to have been classed as inflammation of the brain, there being not one entry except under that head; 1872, '73 and '74 having respectively 257, 251 and 244 deaths due to that cause. From 1875 to the present time, brain inflammation would seem to have steadily decreased and meningitis to have steadily increased. The deaths for 1892 being: brain inflammation 43, and meningitis 222. The steady change of the ratio makes it plain to my mind that the difference represents a change in nomenclature, and not in the prevalence of these two diseases. In these years I have found only 14 deaths set down to otitis and *otorrhœa*. A very little reflection will show that this must represent only a small part of the mortality which has ear suppuration for the primary cause. As, for instance, I know of two cases of deaths from brain abscess, of

which the primary cause in each was an old neglected otorrhœa, occurring in 1892, and that year I find two deaths set down to brain abscess and none to otitis. All of which merely shows the difficulty of getting any data showing even approximately the real mortality from suppuration in the temporal bone.

Thus, while I cannot say how many deaths have suppurative ear disease for the primary cause, this I do claim, that all this loss of life might easily be prevented by the application of that same careful antiseptic treatment to inflammatory disease within the temporal bone which is now almost universally applied to purulent affections of all the other bones of the body.

The chief trouble is the widespread neglect by medical men generally of the study of the pathology and clinical features of the commonest ear diseases. Men who have taken pains to become familiar with the laryngoscope and ophthalmoscope and the diseases they reveal almost show a pride in professing complete ignorance in regard to matters relating to the dangerous processes going on within the cavity of the temporal bone which we call the ear; processes which are less difficult of study and are certainly not less important.

Among the most dangerous ear affections the question of the patient's present and future welfare is often determined by the treatment of the first few hours of the attack and every physician and surgeon ought to be competent to recognize such affections and to treat them promptly.

As to the *etiology* of these suppurations in the temporal bone, in the list of primary exciting causes come first the

acute specific fevers; next, acute and sub-acute catarrhal affections of the naso-pharynx; and lastly, traumatism or suppurations spreading from the external meatus through the membrana tympani. Any of these suppurations may be accompanied by those secondary septic processes which we have learned to dread in all parts of the body, but which occurring here in close proximity to the brain and other important structures, are peculiarly dangerous.

The minute pathology of these particular putrefactive changes has within the last few years been greatly advanced by the discoveries in micro-biology which have so largely enriched our knowledge of the causation of disease in other parts of the body.

It seems highly probable, from the bacteriological investigations of Zaufal and others, that in the production of those forms of acute otitis media, due to cold, which are accompanied by catarrh of the naso-pharynx, the pneumo-bacillus of Friedlander and diplococcus of Fraenkel play an important part. Rohrer's observations are particularly interesting from their completeness. He examined the discharges from the ears of 100 patients suffering from otitis media, both directly by stained cover-glass preparations, by cultivation and by inoculation experiments on animals. The first point noticed was a great contrast between the *fœtid* and the *non-fœtid* discharges. In the former both cocci and bacilli were always found together; in the non-fœtid, on the other hand, cocci alone were present. In the offensive secretions there were about 58 per cent. of bacilli to 42 per cent. of cocci, of which half were diplococci. The odorless discharges, on



the other hand, showed only cocci, of which some 50 per cent. were staphylococci, 26 per cent. diplococci, 19 per cent. monococci, and 5 per cent. streptococci.

Rohrer came to the conclusion from his inoculation experiments that the bacilli found in the foetid secretions were not pathogenic, the inoculated animals continuing alive and well at the end of some months.

The inoculations from the cocci always produced typical septic diseases of various kinds. This seems to me a matter of great importance and the fact that many brain abscesses follow and are due to non-offensive discharges from the ear should cause us to be even more guarded in the prognosis of a chronic otorrhœa when the discharge is not offensive. Further, bacteriological study has brought out the fact that those peculiar growths in the middle ear with which we are all familiar and which are known to our German brethren as cholesteatomata, are more largely infested with dangerous micrococci than any other collection in the cavities of the temporal bone and in this we have the explanation of the great frequency of fatal complications when this material is present; and incidentally of the urgent necessity when operative measures are instituted in those cases that they be as thorough as possible.†

Treatment. Middle ear suppuration is classed under the two heads, acute and chronic. The acute attack beginning with a sense of fullness in the ear and impaired hearing. Pain usually follows, sometimes of a severe character. The drum membrane ruptures and there is discharge from the external canal. Pain

generally ceases with the beginning of the otorrhœa. A large number of acute cases go on to spontaneous recovery and this well-known fact probably accounts for the indifference with which these cases are looked upon by most physicians.

I trust no one in this audience has ever told an anxious mother that a discharge from the ear is a good thing; that it relieves the system and if stopped may break out in some more serious place; that if left alone the child will out-grow it. If consulted in the first stage, before the discharge begins, I have found the best treatment to be very hot water poured into the ear and the application of one or two leeches to the tragus. Inspection shows the drumhead to be red and bulging and if the above does not promptly relieve the pain I always do a paracentesis. With the discharge established I think 99 cases in every hundred will recover in a very short time if the external canal be *thoroughly cleaned* twice a day, and after this be done the pus remaining in the middle ear be driven out through the opening in the drum by inflation through the eustachian tubes either by the Valsalva method or the gentle use of the Politzer bag. There are several methods of cleaning the external canal; that by syringing is good enough if it be properly done. First, the syringe must be one which can be used with one hand, for the second hand of the operator, whether it be mother, nurse, or physician, must be used to pull the auricle up and out and back, for only in this way can a stream of water be made to penetrate to the bottom of the canal. The water should be as hot as can be borne and it is surprising how hot this is. After careful syringing, the canal

† Barker; Hunterian Lectures, 1889, on Intracranial Inflammations Starting in the Temporal Bone.

is to be wiped out with small pledgets of cotton on the end of an applicator or of a toothpick. When this is done and the cotton gently pressed to the bottom of the canal, one or more drops of pus will still be found there, showing how exceedingly difficult it is to cleanse the canal thoroughly. The syringing and wiping should then be continued until there be no pus left.

Another excellent and efficient method of cleansing is by the use of cotton and applicator. If the cotton be used dry it is a long and tedious process, requiring a good deal of skill in the manipulation. If the pledgets be dipped in a solution of hydrogen peroxide the cleansing is greatly facilitated.

It is not to be expected that a mother or nurse can do this cleansing in the complete way required without having been taught by at least one full, practical demonstration by the physician. If the ear be kept clean as above I rarely have to use any medicaments in the way of powders, drops, or salves in the acute suppurations when only the middle ear proper is involved. When, as happens in a certain number of cases, the chief seat of the suppurative inflammation is in the attic or the mastoid cells and there is not sufficient outlet for the pus by way of the opening in the drum, or there may be no pus in the cavity and the ear is swollen and bulging, with much pain and swelling over the mastoid cells, it is sometimes necessary to make an opening through the mastoid, at times all the way to the attic itself. I have found here, however, great benefit from the use of leeches, and greater still from Wilde's incision behind the ear, of which the following case is a good example.

CASE I.—M. D., 3½ years, was brought to my office February 25th with the history that in January she had had an ear-ache, followed by discharge from the ear. This had continued and had been treated by syringing with warm water. Pain had returned on the 23rd. On the 24th, the ear began to swell and project from side of head. The father stated that nobody at home had slept for two nights. Inspection showed the ear to be discharging freely, with much redness, swelling and tenderness above and behind the pinna. No fluctuation could be made out; child was restless and feverish. Operation was advised and consented to, but as the home was in the country beyond Waverly, it had to be deferred until the afternoon. At 5 P. M., the same condition prevailing, Dr. Hartwig administered chloroform and I made a free incision through the swollen tissues behind the ear down to the bone, and a smaller one at right angles to the first posteriorly. No pus was found. The bleeding was encouraged for a short time and then the wound was stuffed with gauze and a mass of cotton placed over it, the whole held by a bandage. About 6 o'clock the child took some milk and then slept quietly until seven the next morning and awakened bright and lively. There was not another troublesome symptom, and on March 1st, three days after the operation, the child was at the office, with no pain and no discharge from the ear. The wound behind the ear was granulating nicely. On March 6th, the father reported the child well. The wound healed and only a scarcely perceptible deafness on that side remained.

In the treatment of chronic suppuration in the temporal bone, strict cleanli-

ness as in the acute cases is all-important and will cure many cases; but when the suppurative process has been long continued the changes in membrane and bone are so varied that any rational treatment must be based on the conditions present in each case. Sometimes the perforation in the drum membrane is small and high up, thus leaving a small quantity of pus in the middle ear after the most thorough cleansing. In such cases a special tympanic syringe must be used and sometimes also the opening enlarged. Granulations and polypi are very often present and must be removed completely before the otorrhœa can be expected to cease. The most obstinate cases of discharge from the ear are due to caries taking place in the ossicles, the wall of the tympanum, or the mastoid cells. Here the treatment is nearly always by operative measures to the end that the broad principles of modern antiseptic surgery should be carried out. A way must be made for free drainage, cleanliness and the application of antiseptic remedies, whether this be by removal of a part or all of the membrana tympani, or one or more of the ossicles; or by a bold and free opening through the mastoid all the way to the attic if necessary. In the way of medicaments there is no one remedy which will suit even the majority of cases. I have derived most benefit from solutions of boracic acid in alcohol, gr. xx to 3i. Only in cases where the whole or a large part of the drum is absent have I derived benefit from dry powders. Among the most useful may be mentioned boracic acid, and one made of equal parts of salicylic acid and oxide of zinc. In many cases yellow oxide of mercury ointment,

gr. ii to 3i, has acted like a charm. In the way of internal, or rather constitutional remedies, mercury and potassium iodide in suitable cases often do good. Tonics and food are all-important when needed. Further than this, I think medicines by the stomach quite useless.

In regard to the removal of granulations and polypi, after using the curette or snare I touch the remaining roots with a fine galvano-cautery point. It is a somewhat delicate operation, but in my hands has proved highly satisfactory.

Then, to sum up, the treatment of long-standing discharges from the ear: Examine the case with the utmost care, locate exact spot of the disease, see to it that good drainage is established and that the remedies used come in contact with the diseased tissues, performing the operative measures necessary to this end.

Here a word of caution is necessary in regard to hasty and ill-advised operations on long-standing cases. Frequently quite severe reaction follows efforts to remove granulations and masses of inspissated pus. This I think is to be explained by the inoculation of new wounds by the micrococci present and the neglect to make the operation sufficiently thorough. In dealing with cholesteatomata this is all-important. I think it possible that the unfortunate termination of the following case may have been due to this cause.

CASE II.—J. N., a strong, vigorous man 39 years old, had for many years an otorrhœa from the left ear. He had been treated by syringing and the use of various local remedies without much



benefit. He consulted a new physician of this city for some nose trouble. A nasal polypus was found and skilfully and successfully removed. Attention was then called to the ear and an examination showed a number of granulations or small polypi at the bottom of the meatus, and an attempt was made to remove these by snare and curette. The following day, while at work as foreman in a packing house, he was seized with a sudden vertigo and had to be taken home in a carriage; this was on Thursday. Friday and Saturday the man was confined to his room, and most of the time to his bed, with violent pain over the side of the head. The discharge from the ear almost ceased. On Sunday I was asked to see him in consultation, and did so about noon. His condition at that time was said to be decidedly better than for the past two days. The discharge from the ear had again begun to be quite free and the pain was much less. There was very slight tenderness over the mastoid. He had been delirious on Saturday. When I saw him his mind was clear, but I noticed as suspicious his seemingly slow cerebration. He answered all questions correctly, but with great deliberation. On inquiry, I was told that he always spoke slowly. I advised an operation through the mastoid but did not urge it strongly on account of the above-noted improvement in the condition over that of the previous day. The ear was cleaned out. Three 10 gr. doses of potass. iodide were ordered, and I did not see him until the next afternoon. We then found him moaning and tossing from side to side of the bed, delirious, and with full bounding pulse. The serious condition of things was recognized

and as a possible hope of saving life an operation was advised and consented to. About 6 P. M., chloroform was administered and the mastoid opened with a drill and gouge. The bone for a distance of  $\frac{1}{4}$  inch was firm, hard and compact, like ivory. At the depth of a little over half an inch a cavity was found from which about a drachm of pus was liberated. This was washed out and a drainage tube inserted. The patient died about seven hours later, without having regained consciousness. No autopsy could be obtained and the certificate attributed the death to brain abscess, with otorrhœa as the primary cause.

Another case with better results may be added.

CASE III.—Mr. P. In answer to a telegram from Dr. Goldsborough I went to Cambridge, Md., February 9th, 1892. I found the patient, a boy of 17, suffering greatly and much emaciated. He had had otorrhœa of some months' standing, following an attack of the grip. For some weeks previous to my visit he had been completely deaf on the affected side, the right. The discharge had ceased. During this time his temperature had ranged from  $100^{\circ}$  to  $105^{\circ}$ ; great pain over the side of the head, and the most persistent nausea. For two weeks he had been unable to retain anything on his stomach. All sorts of medicine and food had been skilfully administered without avail. There had been at times swelling and tenderness over mastoid, but at the time of my visit both were lessened, though present. The appearance of the boy was such as to make it apparent that unless relief were speedily obtained death would shortly ensue. Under chloroform anæsthesia the mastoid was opened, partly

by chisel, but chiefly by help of the gouge. The bone was at first very hard and compact, but after penetrating to the depth of  $\frac{3}{4}$  of an inch was found soft and mushy. Only a small quantity of pus was found. The following day, however, there was a free discharge of pus through the opening. He craved and retained all kinds of food and went on to recovery with the loss of hearing on that side. The wound was kept open and clean, and healed from the bottom after about six weeks.

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### A CASE OF MALIGNANT SYPHILIS RESULTING IN DEATH. \*

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J. P., born in France, aged forty years; chef. Good family history and excellent health (never having been sick since childhood) until the appearance of a chancre twenty-two days after exposure, which soon took upon itself a phagedenic character, and was shortly followed by induration of the inguinal glands.

Nine days after he first noticed the initial lesion the patient was suddenly confined to his bed with all the symptoms of an acute attack of rheumatic fever, and was, indeed, so treated by his physician for a period of four weeks. At the expiration of this time, the disease being apparently no better, the doctor was discharged and I was called in to the case.

After a careful examination I discovered a suspicious eruption on the body (roseola), and obtaining the above history verified the presence of the chancre which had not yet thoroughly cicatrized and bore evidence of its destructive ravages.

The pains complained of were not solely localized to the joints, which were, however, hot and slightly swollen, but were also particularly severe in the long bones of the leg and characterized by their nocturnal exacerbation.

Examination of the internal anterior surfaces of the right tibia in its upper third revealed the presence of a small tumor, intimately connected with the bone. It measured  $5\frac{1}{2}$  centimetres in its transverse diameter by  $4\frac{1}{2}$  centimetres in length, and projected to the extent of about 1 centimetre at its most salient part, but the edges were insensibly lost in the surrounding tissue. To the touch it was almost as hard as the bone itself, and was surrounded neither by oedema nor peripheral inflammation, and the skin covering the part was both healthy and mobile.

The patient claimed to have noticed its presence for about ten days, but was certain that it was at no time attended by external evidences of inflammation, and thought that its growth was most rapid at the onset. The localized pain, which dated from its beginning, was extremely lancinating, but paroxysmal in character and greatly increased by the slightest movement.

The fever at this time was rather quotidian in character, the morning temperature averaging  $99.5^{\circ}$ , and rising in the evening to about  $103^{\circ}$ , unaccompanied by chill but by an intense cephalgia which

\* Read before the Philadelphia County Medical Society, April 26, 1893.

continued for a period of three or four hours each evening, after which a profuse perspiration took place.

Under the mixed treatment the case rapidly improved, and the patient was able to resume his occupation in two week's time. The growth in question slowly diminished in volume and had practically disappeared in about one month with the exception, however, of slight permanent thickening at the crest of the tibia, which remained the seat of occasional intermittent pains.

Three weeks later (about ten weeks after the appearance of the chancre), during the office treatment my attention was called to the sensation of pain referred to the roof of the mouth during the act of eating.

An examination of the part showed a considerable amount of brawny swelling, together with a deep, irregular, yellowish ulcer near the medium line, about  $2\frac{1}{2}$  centimetres in size, and surrounded by a line of inflammatory redness. A few days afterward the ulceration in question was noticed to have spread considerably and had apparently invaded the deeper structures.

Notwithstanding all local treatment directed to the part in conjunction with internal medication, the destruction of tissue continued until the bone itself became affected. About this time the patient was seen by Dr. William G. Porter in consultation, but in spite of our united efforts necrosis of the hard palate as well as of the alveolar processes of the superior maxillary bone and of the nasal bones occurred in turn, and the ulceration only assumed a latent condition during the last half of the malady when a perforation the size of 6 or 7 centime-

tres had taken place. This was attended by the loss of several teeth, and imparted in the voice the nasal sound characteristic of this affection. Shortly after the beginning of the necrosis the patient commenced to rapidly lose in weight and strength, and a marked cachexia became an important feature of the case.

A pustular eruption of the face and scalp was now noticed. The bone pains returned and the debility was so great that the patient was confined to the house. Curious to state, the appetite was greatly increased; indeed, the condition of syphilitic boulimia, so well described by Fournier, soon became manifest, as on several occasions during the absence of the wife, the patient invaded the pantry and partook, according to his own estimate, of enough food to satisfy three or four men.

It may be *apropos* to mention here that the patient had become, to a certain extent, accustomed to the trouble occasioned by the passage of food and could now swallow fairly well.

This condition was attended by little digestive disturbance beyond on rare occasions, slight attacks of diarrhœa; but, on the other hand, gastric crises became an important feature and seemed especially to be aggravated by any form of mercurial treatment. These painful attacks continued throughout the progress of the case, and were equally noticeable during a course of restricted diet.

In the eighth month the anæmic condition was extremely marked, and the patient from a weight of one hundred and ninety pounds was reduced to one hundred and forty pounds. In despair he entered the Pennsylvania Hospital, but



remained only for a few weeks, his chief grievance being the restricted diet to which he was subjected, and which ill accorded with his continued enormous appetite. During this, as well as on previous occasions, careful and repeated examinations revealed no disease of the special organs.

An examination of the blood showed three millions of red corpuscles per cubic millimetre and a diminution of the hæmoglobin to forty per cent. An anæmic basic murmur as well as venous souffle were also to be detected.

Added to this, prostration, the sallow complexion, pallid face, pinched features and sunken eyes, make a picture long to be remembered.

In the tenth month œsophageal obstruction was complained of, and an examination by bougie, made by Professor E. Laplace, showed some constriction, which, however, did not become extreme. At this time localized pains in the lumbar region began and soon became excruciating in their severity. This was attended by occasional loss of control of the sphincter of the bowel and remained present until the close of the disease.

Some three weeks before his death he was removed from under my care to the Medico-Chirurgical Hospital, but the prostration became more marked and he died a little over one year after the beginning of the disease.

Unfortunately, notwithstanding strenuous efforts, a post-mortem was refused.

As may be imagined in a case of the above character, our treatment was as varied as it was unsuccessful.

Early in the case the exhibition of either mercury or of iodide of potassium

seemed to aggravate the gastric crises, and, besides, to be followed by an irritative diarrhœa. Inunctions were tried in turn, but with similar results. Fumigations were likewise discontinued for the same reason, and even the recently vaunted hypodermatic method was certainly open to the same objection. Of the number, the inunctions were continued for the longest period of time. General tonic treatment, although better borne, was of little apparent use.

On investigating the literature of this subject I find a rather growing tendency among the more recent syphilographers to appreciate that our accepted laws regarding the three fixed and precise stages of the disease must be amenable to some modification.

For example, Keys, in his last edition, writes as follows: "The line between secondary and tertiary syphilis is not always well marked, and although in typical cases the lesions become progressively deeper, commencing as mere efflorescences in the secondary stage, and gradually increasing in severity to the most extensive ulcerations and destruction of bone and cartilaga in the tertiary; yet some of the symptoms naturally belonging to the secondary group, as the mucous patch and scaly eruption, frequently crop out in the tertiary stage, while more rarely nodes come on with early syphilis, and occasionally most extensive ulcerative or other tertiary (gummy) lesions appear within the first few months after chancre, perhaps all the lighter secondary eruptions having been omitted. This latter form is called malignant syphilis." Osler tells us (*Practice of Medicine*, 1892) that "in exceptional cases, manifestations which

usually appear late (such as gummatous growths) may set in even before the primary sore has properly healed."

C. Mauriac, one of the most eminent of the French authorities, in his very interesting work (*Mémoire sur les Affections Syphilitiques precoces du Systeme Osseux*, Paris, 1872), details the history of a number of cases, of which the following is a short *résumé*:

OBS. 1.—Case beginning with indolent enlargement of both inguinal glands. Eight days afterward appearance of chancre. On the twentieth day of the initial lesions attacks of cephalgia with appearance of frontal tumors. Then secondary symptoms, cutaneous and mucous, etc. Mixed treatment. Cure.

OBS. II.—Period of incubation of two months' duration. Short duration of secondary symptoms. Parietal tumor with neuralgic pains.

OBS. III.—Omitted. Dates uncertain.

OBS. IV.—Chancre of lip; swelling of cervical glands. One month afterward slight secondary symptoms followed by tumor on parietal bone.

OBS. V.—Syphilis of five months' duration without treatment, tumor in fronto-temporal region, etc.

Mauriac claims that these nodes are the results of periosteal inflammation, and tend to spontaneous recovery without suppuration, etc. But he quotes an account of a case reported by Dr. Henri Roger, which results in a different manner:

A girl, aged two years, acquired syphilis (kissing an infected mother), presented the following lesions at the same time: 1. Indurated chancre on the superior lip not yet entirely healed. 2. Copper-colored spots of roseola on

thighs, on forehead, nose, and cheeks, and mucous patches on the vulva and anus. 3. Multiple exostoses; gummy tumors of the frontal bone the size of a filbert, skin-covering healthy; semi-soft consistency; the right one reddish and shining at apex, imparting the sensation of fluctuation, and did in time suppurate.

Mauriac details the occurrence of other cases presenting similar lesions in the bones of the legs, sternum, and other parts of the body.

In these thirteen cases the shortest period of incubation after the appearance of the chancre was fifteen days, and the longest one hundred and twenty days. Curiously, the shortest of the series presented a history which resembles in part the one forming the subject of this paper. Briefly stated it is as follows:

OBS. VII.—Urethral chancre in a man aged nineteen years, of habitually good health, which showed itself one month after his first connection. On the forty-fifth day acute pains in the tibia, followed in from twenty-six to forty-eight hours by the spontaneous appearance of a bony tumor. Alteration of general health. On the sixty-ninth day well-characterized roseola. On the sixtieth day diminution of tibial tumor and final disappearance. Four and a half months later mucous patches on lips and prepuce. Papular syphilis, etc.

Vidal de Cassis (*Traite des Maladies Veneriennes*, 2d edition, pp. 479, 480) reports a case of a tumor of the right clavicle occurring one month after chancre. The skin-covering is perfectly healthy, the tumor twice the thickness of the bone. Extreme localized pains. Cure in two months time. Dr. Guyot

(*Societe Medico-Chirurgicale de Paris*, July, 9, 1868) reports a case of syphilitic periostitis of the first metatarsal bone, fifty-six days after infecting exposure.

According to M. Daga ("Documents pour servir à l'Histoire de la Syphilis chez les Arabes," *Archives de Medecine*, 1864, t. ii. p. 314), syphilis is so severe among the Arabs that it is not rare to witness in the same subject the presence of syphilides, of gumma, and of multiple exostoses. Tertiary symptoms themselves may be observed at the very beginning of the disease.

According to the researches of M. Maltegasza, syphilis pursues its course with great rapidity in South America, and manifests itself from the beginning not only by superficial cutaneous and mucous lesions, but by osseous lesions and even the destruction of the bones of nose almost immediately after the appearance of the chancre, and always before its cicatrization. (Quoted by Mauriac.)

As eminent an authority as Prof. Hutchinson, of London ("Some of the Moot Points in the Natural History of Syphilis," *British Medical Journal*, January 23, 1886), reports the following interesting case:

"A young man, aged twenty-one years—too young, let me note, for it to be likely that he ever had syphilis before—was admitted into the London Hospital. He had still the remains of a hard chancre on him which was ulcerating in places. The date assigned to the beginning of affection was only four months previous. He died suddenly and unexpectedly. The necropsy showed gummata in both testicles, in the spleen and in the heart, death having been caused by the softening ulceration of the latter."

He adds, in conclusion:

"I have urged that many of the phenomena of syphilis usually counted as tertiary really occur, as a rule, in the early periods, and there is no structure of the body which may not be attacked in the secondary stage. As an instance of this fact, I have mentioned rupia, periostitis, and disease of the viscera and nervous system."

Dr. R. W. Taylor, of New York, in an article entitled "Precocious Gummata" (*American Journal of Medical Sciences*, July, 1887), describes several interesting cases of that form of the skin affection. He says, in conclusion, that these lesions may appear as early as the second, third or fourth month after the initial lesion, and may terminate in ulceration.

Records of early syphilis of the nervous system are also obtainable.

Taylor reports a case of hemiplegia in the fifth month.

Bassereau and Vidal de Cassis, one of facial paralysis a few weeks after appearance of chancre.

Van Buren and Keys and Fournier respectively give instances of several cases of different forms of paralysis occurring before the fifth month.

Fortunately these cases are very rare. For example, Mauriac mentioned that the thirteen cases reported by him represented an experience of over four thousand cases. Whether they represent an unusual amount of the virus absorbed, or an undue susceptibility on the part of the individual is an open question.

The generality of opinion would seem to indicate the possibility of a severe syphilis following a case of phagedenic chancre, as in this report. For example,



Batington tells us (Ricord and Hunter, *Venereal Diseases*, 2d edition, p. 371) that "the symptoms which follow the phagedenic sore are peculiarly severe and intractable. They commonly consist of rupia, sloughing of the throat, ulceration of the nose, severe and obstinate muscular pains, and similar inflammation of the periosteum and bones. Similar complaints will follow ordinary chancre; but when they follow a phagedenic sore they are very difficult to be cured; and it is not uncommon that the constitution of the patient should at length give way under them, and that the case should terminate fatally."

Bassereau (*Histoire Naturelle de la Syphilis*, p. 84), as well as Diday, agree in the main regarding the above statements.

Bumstead and Taylor (*Venereal Diseases*, 5th edition, p. 499), in commenting on the above, express themselves as follows: "Admitting the truth of this rule, it does not follow that the condition of the chancre in any manner determines the severity of subsequent symptoms, but merely that it is an indication of the activity of the virus and of the state of the patient's system—the two causes upon which the severity of the attack chiefly depend."

The latter observation does not corroborate the history given both by my patient or the members of his family. It was particularly claimed that he had enjoyed unusually good health throughout his life, and the quantity of alcohol which he made use of was not in excess of that commonly used in his occupation.

Regarding the presence of the nodules on the tibia, these latter occurred after

a longer period of time than in the one case (Obs. VII.) reported by Mauriac, yet the gummatous ulceration of the hard palate at so early a period is, as far as I can discover, without a detailed precedent, and certainly places this history prominently among similar records.

#### IMMUNITY BY SATURATION.

In the *British Medical Journal*, July 1891, Drs. Brunton and Bokenham narrated some experiments which they had made with potassium chloride administered to guinea-pigs with their food so as to saturate them, as far as possible, with the drug.

These experiments were made with the view of ascertaining whether such an artificial alteration in the mineral constituents of the body would alter its resistance to the attacks of an infectious disease. The results of the experiments showed that saturation of an animal with potassium chloride in no way conferred immunity against anthrax; in fact, that the animals thus prepared died more rapidly than the control animals inoculated with the same virus.

In the present series the authors have tested the effect of feeding with salts of calcium, strontium, magnesium, and aluminium. The number of experiments is by no means large, but the results were so little satisfactory, and showed so little protective power on the part of any of these drugs, that it seemed undesirable to increase the number. Appended are the details of the individual observations.—*Therapeutic Gazette*.

Swabbing the urethra with nitrate of silver, ten per cent., through the urethroscope in recent gonorrhœa is said by Dr. Christian to be a failure.

## MARYLAND MEDICAL JOURNAL,

A Weekly Journal of Medicine and Surgery.

A. K. BOND, M. D., Editor.


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BALTIMORE, JUNE 24, 1893.

### Editorial.

#### THE THERAPEUTICS OF MERRY LAUGHTER.

We say "merry laughter;" for laughter is of many sorts. There is the laughter of derision; the laughter of mere nervousness, finding its acme in the school-girl's giggle; and that nameless laughter, peculiar apparently to Americans, utterly incomprehensible and offensive to Europeans, the laughter of attention. All of these are suppressed or abbreviated forms of laughter, and so are excluded from our consideration at this time, having no therapeutic influence.

But the laughter of pure merriment! What do we not owe to its genial influence! What would this world, what would society, be without it!

A merry laugh is the index of a sunny disposition, of a happy heart. It cannot be counterfeited. Its place in nature can never be filled by the "smile" of over-wrought civilization, with which

the countenance of the social automaton is "sicklied o'er" at stated intervals.

The physiology of merry laughter is worthy of study. It is the dance of the diaphragm, which trips rhythmically upon the underlying abdominal organs, exciting peristalsis and quickening the flow of the life-bearing blood-current. We may believe that beneath its benign rule also the wholesome secretions of the pancreas and liver are poured out in greater abundance upon the contents of the digestive canal, sweetening, and checking abnormal fermentations. The lungs, too, profit by the deep indrawing of fresh air into their lowermost parts and the excretion of effete matters from their remote recesses. And, in sympathy with this jubilee of the great inward organs, the windpipe is opened widely and the voice breaks into ripples of mirth; while the eyes twinkle and the muscles of the face circle into fæcial wreaths of jollity.

Surely, such a healthful habit must not be allowed to vanish from the earth. Every philanthropist must protest against such a robbery of life's treasure-house. The vices which pollute the fountains of pure laughter; the lust for gain which atrophies the faculty of mirth; the philosophy which stifles merriment; must all yield to the pressure of human need and give way to customs and teachings more in accord with the hygienic laws of the human body. Even the so-called "culture of higher civilization," which obliterates the happy, careless age of childhood and youth, and, robbing laughter of its element of internal massage, reduces it to a useless and emasculated "relaxation of the features," must bow before the truer needs of life. Systems of "physical

culture" which banish merriment and laughter from the exercises of the growing youth of either sex must end in failure. The treadmill and the galley, however scientifically constructed, can never become ideal gymnasia.

Let the physician take warning; and, if he has neglected her, begin at once to woo back the coy Goddess of Merry Laughter.

### DRY ASEPTIC OPERATING.

Although for a time overshadowed by the development of the antiseptic solution, dry dressing for wounds has never quite withdrawn its claims for recognition. It is therefore quite natural that as the era of antiseptic irrigation of wounds gives place to simple aseptic treatment the dry method should again appeal to the attention of the profession.

In the *American Journal of Medical Sciences*, June, Drs. Richardson and Mumford, of Boston, present an elaborate plea for this method, which is described as follows:

It is on the use of dry sterile gauze that the proper treatment of the wound depends, and this material must be of an absorbent quality, soft and free from grease. In practice, the familiar Clapp's gauze has been found admirable.

This is simply prepared. A bundle is made up, cut in strips of suitable length, from six inches to a yard, and in number from ten to fifty. The bundle is wrapped in a towel and exposed to concentrated steam-heat for an hour. The moist bundle is then dried by being placed in a warm oven for a few minutes, and is ready for use. Gauze so prepared has experimentally been found

sterile after a week. The advantages of the steam sterilization are that it is more speedy and the material remains soft and pliable. There is no danger of it becoming rotten and frayed, as after prolonged exposure to a high, dry heat. Even when not dried in the oven the gauze loses its moisture quickly when exposed to the air, so that this rapid-drying process may be omitted at discretion.

Many surgeons have these gauze strips turned in at the edges and made up into small pads. This is according to the individual fancy, but is certainly a great unnecessary trouble. The unturned edges fray but little, and the few sterile particles of lint have never been found to disturb the healing of the wound.

The use of these dry gauze strips during the operation differs essentially from that of sponges. Instead of mopping we tampon. So far as the free use of the knife will allow, the cut surfaces and edges are packed rapidly with gauze, which is left behind as the surgeon advances. All vessels except those of considerable size are thus controlled, the large bleeding-points being caught, of course, by pressure forceps.

The result is that when the work of the knife is concluded, the wound remains securely tamponed. The gauze must then be held firmly in place for a few minutes, and on its removal a clean and absolutely dry wound is disclosed. Torsion and a few fine silk ligatures complete the hæmostasis absolutely.

The stitches should now be placed at once, without any further attempt at mopping or washing. If the operator prefers, he may place his sutures before



removing the gauze, but this is usually unnecessary, and often objectionable, as the subsequent dragging out of the tampon may bruise the surface and start up fresh bleeding, which is not so likely to occur when the packing is gently lifted out.

It is obvious that the fresh surfaces are now most advantageously prepared for an immediate union. More properly the advantage lies in the lack of preparation. No chemical remains, no detritus is present, but natural processes, uncomplicated, are allowed to complete the healing.

In the past twenty-six months the private practice of the writers has included 130 aseptic major operations, involving healthy tissues only. Of these, one did badly. This was a case of double pyo-salpiux, aseptic in so far as the tubes were removed without apparent rupture. The abdominal wound failed of primary union, but the patient eventually recovered, and is now, two years after the operation, perfectly well.

This list comprises 32 breast excisions with axillary dissection; 44 abdominal operations (including 14 ovariectomies, 4 cholecystotomies, 1 pancreatic cyst, 2 extra-uterine pregnancies, 1 nephrectomy, 4 hysterectomies); 2 amputations at the shoulder-joint; 2 of thigh and 2 of leg, and 1 of forearm; and a dissection of 19 large tumors in different parts of the body, with 27 miscellaneous operations. For obvious reasons all pus cases, including appendicitis, caries, etc., are excluded.

Since the adoption of the dry treatment we have found that the convalescence of our patients is much shorter.

After excision of the breast and axillary

glands many patients go home in from ten days to two weeks, instead of in three or four weeks, as formerly. After amputations of the leg convalescence lasts from seven to twelve days; after clean abdominal sections, two weeks; and minor operations in proportion.

In these statements the writers lay no claim to unusual or especially brilliant results, but feel that a procedure which has been so unquestionably successful in their hands, as compared to their own previous methods, must recommend itself favorably to the notice of many practitioners to whom these measures are not as yet familiar. For the skin incision a separate knife is used.

### Reviews, Books and Pamphlets.

*Diseases of the Rectum and Anus, their Pathology, Diagnosis and Treatment.*  
By Chas. B. Kelsey, A. M., M. D.,  
New York, Professor of Diseases of the Rectum at the New York Post-Graduate Medical School and Hospital; late Professor of Diseases of the Rectum at the University of Vermont, etc. Fourth Edition, brought up to date and enlarged. With two chromolithographs and one hundred and sixty-two illustrations. Octavo, 496 pages, extra muslin, price, \$4.00. New York: William Wood & Company.

Among the important departments of practical medicine which are most often neglected by physicians is this department of diseases of the lower end of the intestinal canal.

Its junction with the skin being gifted with a most sensitive nervous perception, a concealed and otherwise insignificant lesion here may either cause the

most excruciating agony, or else by the continuance of irritation of moderate intensity, throw the whole nervous system of the body out of gear, producing serious chronic illness.

In its upper portion the rectum is, on the contrary, ill supplied with sensitive nerves, and malignant growths here often reach incurable dimensions, while their existence is still unsuspected either by the patient or by the careless doctor.

It is, therefore, of great importance that the general practitioner should possess and be familiar with some special work on rectal diseases presenting clearly, minutely and with personal enthusiasm the knowledge and experience of one who has had large opportunities for observation in this department of practice.

We think that the handsome volume before us fills this demand and therefore take pleasure in recommending it for the purchase of our readers. Although some of the teachings may be still subjects of dispute among rectal specialists, as, for instance, its wholesale condemnation of electrical dilatation in rectal stricture, yet the themes are ably and wisely discussed.

The purchase and careful perusal of such a volume will make errors of diagnosis on the part of regular practitioners less frequent, and will lessen the number of cases which fall to the quacks.

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### Medical Progress.

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#### USTILAGO MAIDIS (CORN ERGOT).

In the *Therapeutic Gazette*, May 15th, Dr. Blair relates a number of cases in which this drug acted favorably. All care-

ful testimony upon this subject is welcome, since, as H. C. Wood says in his therapeutics, "the drug appears to have active principles and should be investigated." We doubt, however, whether its mode of action can be definitely settled outside of the laboratory.

Dr. Blair's comments on his cases are as follows:

Many, in their great desire to hasten the termination of labor, knowing of the power of ergot of rye to excite uterine contractions, but forgetting or unheeding the nature of those contractions, have administered the drug, too often to the great injury of both mother and child. The tonic contractions which it produces, so different from the distinctly intermittent contractions which nature institutes for the safe and complete emptying of the uterus, have only defeated the end for which it was given, and brought added dangers to mother and child. Scientific research and experimentation have recently brought to the attention of the medical profession a drug which bids fair to take a very important place in the armamentarium of the practical and progressive accoucheur. In a brochure, received within the past twelve months from Parke, Davis & Co., of Detroit, my attention was directed to a preparation of a fluid extract obtained from corn smut, and bearing the scientific name "ustilago maidis." Although the drug has been known for several years, it has received but little attention, and it is but recently that its merits have been investigated to any extent in a clinical way.

After reading the brochure above referred to, I procured a liberal supply of the fluid extract, and began an experi-

mental investigation of the drug, the results of which I record.

In those cases where the pain was continuous the effect of the drug was to make it intermittent and more easily borne. Where natural labor-pains were present and the ergot was administered, the effect seemed to be a strengthening of the contractions and a hastening of the labor to termination. The effects of the drug seemed to be more favorable when given after considerable dilation had occurred, though it was administered at all stages. After the ninth case negative results were obtained. In the eleventh case the pains seemed more irregular and weaker after administering the ergot. The fluid extract used had at this time been kept about eight months. Whether a fresh article would have changed the results, I cannot say. In no instance did any bad results follow the use of the ergot which, in reason, could be ascribed to its action.

#### GONORRHOEAL PERITONITIS IN THE MALE.

Circumscribed gonorrhœal peritonitis may occur in men as well as in women. Epididymitis is always present at the same time. Whether the peritonitis is caused by gonococci is not yet determined. The routes of invasion are: (1) the vessels of the spermatic plexus; (2) the vas deferens; (3) the lymphatic vessels of the vas deferens.

A case reported by M. Horovitz illustrates the last named path. A man, 31 years of age, contracted gonorrhœa on the 18th of December. He treated his own case by means of cold applications. On the 29th he was attacked by epididymitis. Suspension, ice, and Epsom salt were employed. On the 1st of Jan-

uary he experienced severe pain in the region of the great sacro-sciatic foramen and extending into the hip-joint. The pain was increased by attempts to move the limb. On the following day the temperature was 102.7°F.; the man had a chill, suffered from sharp pain in the right iliac region and sickness of the stomach. The abdomen was greatly distended and very sensitive to pressure. Recovery took place in three weeks. —*Deutsche Med. Zeitung.*—*Medical Bulletin.*

#### INFECTION IN OPERATING FOR TRACHOMA.

The following editorial note occurs in the *Ophthalmic Record* for February, 1893: The use of the forceps for the cure of trachoma is not free from danger to the operator and assistants, since some of the blood full of micro-organisms may, by accident, be thrown into their own eyes. This occurred to two surgeons some years ago while operating on a case. At the same moment the material was thrown into the eyes of each. The one, believing in the germicidal power of nitrate of silver, at once expressed a willingness to have a few drops of a 10-grain solution put into each conjunctival sac. As his reward he escaped the development of a case of trachoma. The other declined to submit to this preventive measures. His punishment was a well-developed case of trachoma, which was not cured for a long time.—*Ex.*

#### FRACTURE OF NECK OF FEMUR.

In a recent society discussion, Dr. John B. Roberts said: I feel sure that many people have been woefully damaged by meddlesome surgery in the attempt to make a diagnosis between intra- and



extra-capsular fracture. Such a diagnosis often cannot be made by anybody, and if it were, it would be of no service. These fractures should never be subjected to rough movements to make out crepitus or preternatural mobility. A surgeon who cannot readily make a diagnosis of probable fracture of the femur needs some further education, rather than some further knowledge to be obtained by manipulation of the patient. I have seen demonstrations made in hospital clinics to show crepitus and preternatural mobility, which seemed to me to be almost actual malpractice. I believe that many of these fractures are impacted, and breaking up this impaction takes away the only chance which makes union possible. If the fracture is extra-capsular, you will, probably, under judicious treatment, get serviceable union. It seems to me, therefore, that the points brought forward by the reader of the paper are exceedingly valuable if they impress upon the profession the fact that no ether should be given, and no violent manipulation made in suspected fracture of the neck of the femur, or any suspicious injury of the hip in old persons, unless it be made out that there is dislocation.

Where there is not much motion, and not much deformity, there is not much inflammation, and where there is not much inflammation there is not much callus thrown out. A fractured rib will often unite without much callus. An extra-capsular or intra-capsular fracture will unite without the formation of much callus if motion is not permitted. A fractured bone, where there is no displacement or motion, unites by first intention with very little callus. Fractures of the shafts of bones are

much more liable to be the seat of callus, because, as a rule, such fractures are oblique, and the muscles above and below the seat of fracture have more opportunity to act, and cause deformity and motion.

In the treatment of these fractures, I always put on a moderate amount of extension, which does good in preventing muscular spasm, which often is the cause of pain.

### **Recommendations of Therapeutic Agents.**

#### **THE THERAPEUTIC MERIT OF COMBINED REMEDIES.**

In nearly every case where quinia is indicated, it can be advantageously combined with antikamnia, which thus becomes a valuable adjunct to quinia. Quinia, for example, is a most decided febrifuge, and its action is usually promptly reliable; but when combined with this member of the aromatic series, its action is markedly increased. Some individuals, however, cannot take any of the coal-tar derivatives; consequently the use of antikamnia will be inhibited in such cases; on the other hand, some patients cannot take quinine.

An important benefit to be derived from the addition of antikamnia to quinine is that it removes the sense of fullness in the head, constriction about the forehead and tinnitus aurium—so common when the latter drug is administered alone; the disturbing action of quinia on the auditory nerve is suspended to a great extent, and the usual quinine deafness is absent. The combination of these agents in tablet form is a happy one.

The combination of antikamnia with quinia is valuable in the racking headache, with high fever, attendant upon

malarial disorders. It is likewise valuable in cases of periodical attacks of headache of non-defined origin; of the so-called "bilious attacks;" of dengue; in neuralgia of the trigemini; in that of "ovarian catarrh;" and, in short, in nearly every case where quinine would ordinarily be prescribed.

Binz claims specific antiseptic powers for quinia; other writers are in accord with him on this point, and report good results from large doses in septicæmia, pyæmia, puerperal fever and erysipelas. It is a germ destroyer of the bacilli of influenza (in gripe). A full dose of quinine and antikamnia will promptly relieve many cases of this disease. In the gastric catarrh of drunkards, this combination is valuable. Quinia is a poison to the minute organism—sarcina; and antikamnia exerts a soothing, quieting effect on the nerve filaments. A full dose of antikamnia and quinia will often arrest a commencing pneumonia or pleuritis. This combination is also useful in the typho-malarial fever of the south—particularly for the hyperpyrexia—both quinia and antikamnia, as previously said, being decided fever reducers.

The germicide power of quinia is the explanation of its success in the treatment of malarial disturbances. Thus it is also a prophylactic against the various manifestations of malarial poison, and as such it can be relied on. The cause of malaria as a disease consists of pigmented bodies, which penetrate the interior of the red blood corpuscles—pigmented bodies of various shapes and flagellate organisms—both having amœboid movements—the filaments being in active vibration.

In meningeal troubles, attended by marked acceleration of the heart due to the rise in the fever temperature, full doses of quinine and antikamnia at intervals of, say, about four hours, will be productive of good. In measles, large doses of the combination at night—say ten grains of each for adults (doses for children in proportion), will relieve the distress of the catarrhal pneumonia, and modify, in great degree, the amount of the exudative products. The periodical neuroses which may be either regular or irregular in their manifestations, but which are dependent on the malarial germ for their origin, are all controllable by the combination of quinine and antikamnia. Examples of such neuroses are asthma, laryngismus stridulus, summer catarrh, etc. Indeed, for the hemicrania and neuralgias of malarial origin, the combination of quinine and antikamnia, just alluded to, may be declared *a specific*.

The dose of quinine may be made smaller than usual when administered with antikamnia. Thus, one or two tablets of two and a half grains each of quinine and antikamnia will prove sufficient for great utility in puerperal mania, in the headaches of advanced age, accompanied with vertigo and despondency.

This combination is capable, by the combined influence of each drug on the nervous system and blood, of restraining all the processes which develop heat, organic changes, and muscular motion; therefore, it is "the one thing needful" in the treatment of the hyperpyrexia of malarial fevers. In the vast majority of cases, when necessary to administer quinine, if antikamnia be added to the prescription, the results will be surprising.



Formerly, the idea prevailed that in order to render the treatment of periodical fevers efficient, the gastro-intestinal tube should be cleaned out by emetics and cathartics. This, however is a fallacy, as the conditions they are intended to remove depend mainly on the malarial poison, for which the combination of quinine and antikamnia is the specific cure.

In speaking of the treatment of pneumonia by quinine and antikamnia, Prof. Palmer says: "The effects desired, and certainly as a rule produced, are a decided reduction of temperature, a marked diminution in the frequency of the pulse, a decided moisture of the skin or free sweating, a slower and more easy respiration, or relief from pain, and the feeling of fullness of the chest, a diminution of the cough and of the tenacious and bloody character of the expectoration; and, in short, not only is there a checking of the fever, but of all evidences—general and local—of the pulmonary engorgement and inflammation."

In Meniere's disease, or "labyrinthine vertigo," this combination has, by persistent use, entirely removed the trouble in many cases. The curative effects of quinine and the coal-tar antipyretics in sunstroke are well known, and have been used recently with great benefit in numerous instances in this country and in India. In hysteria, and even in epilepsy, the combination of quinine and antikamnia is often indicated, and will frequently give the desired results. In whooping-cough and hay fever, quinine and antikamnia will prove beneficial.

The tablets of equal parts of quinine and antikamnia, spoken of in this article, can be administered by the rectum, with

good effect. They should first be dissolved in whiskey, and then water can be added in any quantity needed—always remembering the total quantity of each drug in such enemata.—Stephen J. Clark, M. D., New York, in *Virginia Medical Monthly*.

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### Our Special Edition.

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The present issue, including 10,000 extra copies, in addition to the regular circulation, to our subscribers and advertisers, represents, as we believe, the greatest effort ever put forth by any medical journal located south of Mason and Dixons' line. We direct attention, with justifiable pride, to the fact that the MARYLAND MEDICAL JOURNAL, now in the eighteenth year of its existence, is fully awake to the extraordinary advances which are being made by the New South in every line of progress, and will make every effort to hold its hard-won but acknowledged position as the representative medical publication of the South. The rising importance of Baltimore as a leading medical centre of America is known to all thoughtful men.

TO THE PHYSICIANS of our own and neighboring States and to the many graduates of our famous medical colleges we offer the MARYLAND MEDICAL JOURNAL as a medium through which they may keep in touch with the best thought and experience of our medical teachers, as well as a storehouse into which are gathered, from week to week, the most helpful and instructive literary and clinical suggestions which other journals have brought to light; the wheat thoughtfully culled from the chaff.



TO MANUFACTURERS of products useful in medicine, we present in the advertising columns of this JOURNAL a most excellent medium through which, at very reasonable rates, the advertisers' goods may be kept constantly before the notice of the profession in the territory which it covers. What better medium can be had than the leading medical journal of the growing South?

TO ALL READERS we offer the present issue as a fair specimen of the regular weekly issues of the MARYLAND MEDICAL JOURNAL, both from a literary and mechanical point of view.

TO NEW SUBSCRIBERS we offer, during the month of July, special inducements, which will be better appreciated and understood by referring to page xiii.

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### Medical Items.

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Dr. Clapham Pennington, with wife and family, will spend the greater portion of the season at Bar Harbor.

At a recent meeting of the Trustees of the University of Pennsylvania, Dr. Charles K. Mills was elected Professor of Mental Diseases and of Medical Jurisprudence.

Dr. Gulick, of Scranton, Pa., who committed suicide on Thursday of last week, by firing the contents of a shotgun into his mouth, was supposed to have been insane.

Dr. Frank West, a very prominent young physician of our city, will go to Deer Park as Resident Physician during the summer months. Dr. West being

well known in the social whirl, will, no doubt, enjoy himself thoroughly.

Dr. Wm. Rickert, formerly of Pennsylvania Avenue, who has been traveling for several months through the west, has returned to the city to resume practice, and is located at the northwest corner Lexington and Carey Streets.

Intending contributors to the Ophthalmological Section of the International Medical Congress, which meets at Rome in September of this year, should forward the titles of their communications to the Secretary, Dr. Parizzotti, with as little delay as possible.

Dr. Thomas A. Ashby, of Madison Avenue, spent several days of this week on a visit to Front Royal, Va. Besides having many friends in Front Royal, Dr. Ashby is interested in considerable property throughout this section of Virginia and his time was principally spent in looking after his interests.

We are pleased to hear that our friend, Dr. John Morris, Ex-President of the Medical and Chirurgical Faculty, is rapidly recovering from the severe injury (a fracture of the tibia of the left side) received about a month ago. We hope that the doctor will soon be able to resume practice.

A young physician of experience and ability would like to assist large practitioner in city—Baltimore or Washington preferred; or would form partnership with one desiring to lessen his labors, and eventually buy practice if desired. Best of references as to ability and character furnished. Address Dr. B. B., care MARYLAND MEDICAL JOURNAL, 209 Park Avenue, Baltimore, Md.

# MARYLAND MEDICAL JOURNAL.

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## Original Articles.

### THE DIAGNOSIS AND TREATMENT OF FRACTURE IN THE NECK OF THE FEMUR IN PERSONS IN ADVANCED LIFE.\*

BY OSCAR H. ALLIS, M. D.,  
Surgeon to the Presbyterian Hospital.

There is no department of medicine in which results are more uncharitably, not to say unjustly, criticised than in injuries of the bones and joints; and in no department is one so frequently called upon to defend himself in the courts.

Fully alive to the importance of the subject, authors and teachers lay great stress upon the importance of diagnosis, and enter into practical minute detail in regard to treatment.

\*Read before the Philadelphia County Medical Society, May 10, 1893.

Proper as such a course may be in middle life, and in most fractures, I think it possible to show that in the particular fracture under consideration, great, even irreparable, mischief may be done in attempts to establish a diagnosis, and that death has not infrequently been the fruit of a blind and too strict adherence to rules.

My subject embraces but two topics for consideration, viz.: Diagnosis and Treatment; and both are to be handled with special reference to the period of life at which the accident is supposed to occur.

#### a. THE DIAGNOSIS.

This I shall discuss under three subdivisions: I. History of the case. II. Inspection (*i. e.*, passive measures). III. Manipulation (*i. e.*, active measures).

#### I. HISTORY OF THE CASE.—Age.

After sixty years of age dislocations of the hip are rare. I have seen but one dislocation after that period, which was in a female. Indeed, so rare are dislocations after fifty years of age (especially in women), that one may reasonably doubt the possibility of their occurrence. If this is probable at fifty, it becomes reasonably certain that at the age of seventy or eighty an injury, whatever it be, cannot be a dislocation.

*The nature of the accident.* If a person be thrown from a rapidly moving carriage, or drop a considerable height, sufficient momentum will be created to make any variety of accident possible. But in very many cases the amount of momentum is not sufficient to dislocate a joint. An aged woman slips from a chair, falls to the floor, and is unable to rise; or in walking along the floor catches her foot in the carpet; she may not even fall, for she may catch hold of something. Cases are on record of aged females turning in bed and immediately complaining of pain in the hip attended with helplessness. One of the most frequent causes of hip injuries is a fall from the standing posture. Now in none of these instances is sufficient momentum created to cause a dislocation, and hence one can, from the history in many cases, exclude dislocation as a possible result of the accident.

*Helplessness.* In all cases where a person is rendered immediately and totally helpless, some grave injury must be predicated. I say immediately and totally. The word immediately may apply to any accident, but "totally" requires limitations. One person will fall, fracture the neck of the femur, rise with difficulty, and by the aid of a friend

or a cane walk home. Another cannot rise. Now I say that so far as the hip is concerned, both are totally disabled. If you observe the mode of progression you will see that scarcely any weight is placed upon the lame limb. I have placed my hand on the floor and asked such a one to step upon it and bear the entire weight upon it, and have thus demonstrated practically how little dependence the patient placed upon the injured limb. If the patient is lying in bed the degree of helplessness may be detected by asking her to flex the limb, or raise it full length from the bed. The imperfect, ineffectual effort, the insinuation of the sound toes beneath the ankle of the lame limb, are eloquent confessions of helplessness.

II. INSPECTION.—The patient lying in bed, the two limbs lying parallel, and both of them for their full length touching the bed all the way down, no possible dislocation is present. On the other hand, if the suspected limb lie parallel with its mate, and full length upon the bed, but at the same time it is shorter and everted, you have good reasons to suspect a fracture; and if the injury occurred in advanced life and from a trifling cause, the seat of the fracture is above the shaft—it is in the neck of the femur. Eversion of the foot may not be present, but if you ask the patient to invert it no result will follow.

III. MANIPULATION.—Thus far the physician has not placed his hand upon his patient. Thus far he has, at least, done him no harm. I am now to take up the active positive measures recommended by authors and teachers which are too often followed blindly and to the patient's detriment.



1st. To prevent unnecessary pain, to overcome the action of muscles, an anæsthetic is often advised. For what purpose; to restore a dislocation? No, but rather to enable the examiner to elicit *crepitus* and to establish beyond a peradventure the presence of fracture and its exact seat. Surgeons have written learnedly upon the differential diagnosis between intra- and extra-capsular fractures; and to be dead-sure, ether, they say, must be administered.

Of all the signs of fracture none is more difficult to elicit or more uncertain than that of *crepitus*. The short fragment is usually not more than an inch in length and perfectly movable in all directions. If, as a fortunate result of the injury, the fracture is impacted, partially attached by bone, or by periosteum, then the short fragment will follow the long fragment and no sense of *crepitus* will be elicited. But the examiner, fully alive to the importance of determining positively the nature of the injury, and knowing that he has abolished pain with his anæsthetic, lifts the thigh vertically and then depresses it, repeating the manœuvre until he is sure of a sense of grating; while to locate the injury, to fix the precise direction of the fracture, to be able to say that it is intra-capsular or the reverse, the examiner requests an assistant to rotate the flexed or extended limb, while he studies the axis upon which the shaft revolves. One surgeon will satisfy himself that fracture is present by rotating the flexed thigh far beyond its normal possibilities, while another, to be certain, hyper-extends the thigh. And all this in a person seventy or eighty years of age, that does not exhibit a single symptom of dislocation,

the only result of an injury that may be benefited by an anæsthetic, or may suffer from delay. I therefore cannot too pointedly condemn the employment of an anæsthetic when there is no single symptom of dislocation, nor too earnestly condemn all rude efforts, after fracture is suspected, to establish its exact locality.

From the history of the case and from inspection, the physician may strongly suspect fracture. It is important to have more than a suspicion. It is important that the diagnosis be reached, and that, too, without mischief or unnecessary pain. To do this no single symptom is, in my judgment, equal in value to that furnished by the fascia lata. This very important structure has a value in locomotion and in the erect posture that few appreciate. It consists of a strong, pliable, but inelastic structure, with a function akin to that of a ligament, and extending from the crest of the ilium to the outer tuberosity of the tibia. In its course it passes over the great trochanter and sends a process of attachment throughout the whole length of the femur. This fascia possesses signal value in enabling man to stand, restfully, upon a single limb. It is of the utmost importance that every physician in general practice should study this fascia, and he can do it best on his own person. The two points where the fascia is most prominent are indicated in the accompanying figures. Now, in case of fracture of the neck of the femur this fascia will be relaxed. It can readily be ascertained while the patient is recumbent, by gently adducting the suspected limb; under normal circumstances adduction makes the fascia tense. If it

cannot be made tense in the injured limb as it can be in the sound, if the fingers can be depressed above the injured trochanter and are resisted upon the sound side, we have a most conclusive demonstration of fracture of the neck of the femur.

In concluding what I have to say upon diagnosis, I will say that in the aged, a slight fall rendering the patient helpless, with the limbs lying parallel, shortened, eversion, and a relaxed fascia lata, all the elements of the problem are present and the conclusion that fracture is present is irresistible, and the diagnosis has been reached without entailing unnecessary pain or aggravating an injury, at best permanently crippling.

#### 5. THE TREATMENT.

My subject on this point must not be misunderstood. It is not treatment of fracture of the neck of the femur, but treatment of fracture of the neck of the femur in the aged. If the last clause is omitted, or for a single moment left out of the problem, the result may be disastrous.

In the treatment of fractures generally, the cardinal principles are *fixation* and *rest*. The important question is, Can prolonged fixation be attained in fracture of the neck of the femur in the aged and feeble? What are the conditions? An aged woman, often with an incontinent, irritable bladder, if she lie quietly upon her back, with splints to hold the limb still, must be disturbed when the draw-sheets are changed; and no matter how often this is done, the whole sacral region is doomed to constant maceration. This, in a person of feeble circulation, and the result is pressure-sores within the first week of treatment.

Then what? Oh, of course, remove the splints. But would it not have been better to have protected the patient against bed sores? No one will ever know the number of deaths due to bed sores, the result of treatment of fractures of the neck of the femur by means of splints and confinement.

What then is to be done? If I were to give a universal rule, I would say, *treat the patient, not the fracture*. But it is asked, What result will follow from non-treatment of the fracture? Let me mention the history of a few cases:

CASE I.—A man, about seventy years of age, fell through the board-walk at Atlantic City, and was unable to rise. He was seen a few hours afterward by a physician of large general practice, who assured the man that he might congratulate himself on having broken no bones, and that he would soon walk as well as ever. He remained at Atlantic City seventeen weeks, with no other treatment than such as would be proper for a bruise, after which he returned to Philadelphia, where he visited the Pennsylvania, Jefferson, and Presbyterian Hospitals. Everywhere he went he was told that he had sustained a fracture of the neck of the femur, and that now he would do as well to move about and regain his strength. Remember that this man had no treatment for fracture from first to last, and to-day he can go up and down stairs without taking hold of the banisters or the help of a cane.

CASE II. Dr. Edwin Graham asked me to see a case that three months before had fallen upon the icy pavement. He arose with great difficulty and was helped home. Thinking he was only bruised, he sought no medical advice,

but finding, at the end of three months, that he was still lame, he sent for his physician. This man was lame, but walking all about. He had only remained in bed for three days, after which he rose daily and sat about in chairs. Result: as good a limb as could have been secured by the most elaborate fracture-apparatus.

These cases could be supplemented by others from the experience of every general practitioner, and the lesson to be derived from them is an important one. The patient unsurgically treated, treats himself surgically and scientifically. Owing to the pain in the hip he is obliged to move with great care and deliberation, but regarding the injury as only a bruise, he asks to be helped out of bed, for he argues that he is as well up as in bed. Thus bed sores are averted, while by deliberate, gentle movements no possible harm is done to the efforts at repair.

Following what I may denominate the "no-fracture-treatment plan," I turn my patient on her sound side the day after the injury. I do not turn the trunk a little, leaving the hips undisturbed, but I turn her fully on her side, usually placing a pillow between the knees for the purpose of comfort and of steadying the injured limb. This turning on the side should be attended to promptly, no later than the second day. It is a painless procedure and yields *so much comfort*. If the patient is doing well get her up upon the chair when her bowels shall require it. In this the general constitutional condition must be considered. The shock of fracture in the aged must not be undervalued. It requires days, even weeks,

sometimes, for such persons to rally, hence the physician will act wisely if he considers the age and feebleness of his patient. There is less need of haste if there is nothing to fear from bed sores, hence daily or even twice daily turning the patient upon the sound side will make it possible to delay getting the patient out of bed.

When the patient can bear removal to a chair, I attend to it myself. This gives the patient confidence and teaches the nurse. While the nurse takes the body, I take both limbs, and turning the patient, I bring the legs to hang over the bed. She then puts both arms around my neck and I place both of mine around her body. She is thus assisted to stand, and turning slowly around, is seated in a chair provided for her. If this is done without haste or excitement, she will not wait for an invitation for a second outing. This will give time to air and fix her bed, and will also have a tonic effect upon the patient's whole system.

I am not now asking you to subscribe to a theory; I am recounting a practice that I adopt in public and in private, and of whose good results I can show many cases.

Let me mention one that bid fair to be most unpromising:

CASE III.—Mrs. J., seventy-two years of age, was knocked down at market and brought home. I saw her in consultation with the late Dr. Rodger Keys. She looked older than her years, from the effects of a disease (paralysis agitans). Incessantly during waking hours her head nodded, her arms shook, and her legs danced. This woman was put in bed on Saturday, and on Monday,



two days later, a small red spot appeared upon the sacrum—the initial step toward a bed sore. This remained for weeks, never getting larger than a three-cent piece, and not going deeper than the true skin, but was prevented from spreading by daily turning patient on her sound side, and in about ten days getting her out of bed into a chair. Had this patient been confined to bed with a fracture-apparatus for a single week, a large bed sore would have undoubtedly been formed. Result of treatment: patient able to walk up and down stairs.

Another case was as follows:

CASE IV.—A clergyman, eighty years of age, was knocked down by a passing carriage. No attempt at confining patient to bed. In consultation with the late Dr. McMurray I saw him from the first and throughout his housing. He was out of bed within the first week, and then daily. Result: walked again, up and down stairs, and, old as he was, returned to his pulpit duties.

Cases like this prove that the let-alone treatment insures excellent results, while it relieves the patient of a vast degree of discomfort, to say nothing of more serious results.

What I have said must not be construed as a wholesale condemnation of surgical appliances. What I specially desire to emphasize is that the life and future of the *patient* is of more value than the broken bone; that the bone will take care of itself if the physician takes care of his patient. If surgical appliances are employed, let them prove their excellence by increasing the *comfort* of the aged sufferer. If implements are employed, those are best suited that can be entirely laid aside daily

while the patient is turned on her side for a rest, or placed in a comfortable chair.

I am now about to make a remark that many of you will accept with caution; it is this: that nature never intended intra-capsular fractures to unite with bone according to the processes she adopts in fractures of the shaft.

1st. She has inadequate nutriment for bony repair. The short proximal fragment is almost without vascular support. To this, it will be replied that the artery of the teres ligament supplies it. Even were this true, the nourishment is scant for such a work. But I do not accept the theory that the head of the bone gets its supply from the teres tendon. This tendon is absent in the elephant, in the anthropomorpha, in the South America sloth, in the orang outang, and occasionally it is absent in man. I believe the ligament has another function and does not contribute to the food supply of the head of the femur.

2nd. What would be the result if fractures of the neck united according to the laws of fracture of the shaft? In fracture of the shaft the provisional callus is often twice the diameter of the bone, and bone, periosteum, fascia, and muscle are all melted down in the inflammatory process. How would this work in fracture of the neck? How would the femur execute its movements with a neck twice the diameter of the head? Such a condition would invite re-fracture, or abridge to a great extent the movements of the bone.

The let-alone treatment is no new mode of practice; it is old as Sir Astley Cooper, and I believe is based on sound hygiene and pathology.

CLINICAL REPORT OF A CASE  
OF HEPATIC ABSCESS.\*

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Medical College.*(For discussion, see page 206.)*

Mr. President and Gentlemen—My only excuse to read a paper before you this evening is prompted by a desire to furnish you with my unfortunate experience, which, probably, might be of some benefit to some of our members.

I was called on the 30th of March last to see a gentleman, sent from the country by his physicians to see whether surgical treatment could not be of benefit to him. Mr. B. was a native of Louisiana; his family history was free from tuberculosis or syphilis. Prior to January, 1892, he enjoyed excellent health; at which time he was first confined to his bed by fever and pain in the right side. After prolonged medical treatment he experienced no relief, and came five months subsequently to New Orleans. This proving of slight benefit to him he returned home, and again came to New Orleans, this latter time five months ago. Being discouraged, having experienced no benefit, he determined to return home and die. Whilst on the train, he was suddenly taken with most violent pains in the affected side, and in another moment he coughed up what he supposed to be a quantity of blood, but which subsequently proved to be liver pus.

The diagnosis of his trouble was quite evident now; his general condition being so much below par, his physician at

home placed him on cod liver oil, quinine and a cough mixture. They did not attempt a free incision to remove the septic material, not knowing exactly where to locate the pus cavity. Thus his condition remained, constantly coughing up pus, continuous septic fever and great progressive emaciation.

Upon taking charge of his case, I immediately explored and located a pus cavity in the right lobe of the liver. I could not make out any definite destruction of lung tissue. There was an abundance of rales; these, however, might have been due to accumulated pus in bronchial tubes. Dullness was well marked at the lower lobe of the right lung. It was quite evident to me that a chronic pneumonia must have supervened from a constant irritation of the septic material coughed up. The day following my first examination, I had him sent to the New Orleans Sanitarium, and, on April 1, under chloroform, I resected the rib and made a large opening into the abscess cavity, removing fully one pint of very foul pus.

Fearing to irrigate under chloroform, as the cavity communicated with the lung and the water might clog up the latter and produce death from asphyxia, I packed the cavity with iodoform gauze and had the patient removed to bed. The patient rallied well; his pulse, as before the operation, was 155 a minute, his respirations 40. The following day I irrigated with a 2 per cent. solution of carbolic acid and substituted a drainage tube for the gauze. The change in his condition the next week was phenomenal; his temperature became normal; his pulse was reduced to 110, stronger and fuller; his appetite was inordinate, eat-

\*Read before the Orleans Parish Medical Society, April 29th, 1893.

ing or asking to be fed whenever awake; his respirations from 24 to 28 a minute. He had been taking a tonic of iron and quinine, and when constipated a little sulphate of magnesia was given. Each day I irrigated the cavity with the carbolized solution, after which I injected peroxide of hydrogen, followed by iodoform and glycerine (5iv to 3vi). On April 15th I went to pay my daily visit. I found my patient in a very gratifying state; he complained a little of his cough, but so confident did I feel in a future recovery that I promised to let him sit up in ten days. He was prepared to be dressed by the nurse in attendance, the patient assisting himself in the preparation. As soon as I introduced the nozzle of the syringe into the wound he began to cough; this was nothing unusual, as I experienced the same difficulty every day. I stopped for a moment, which gave him relief, and began again very gently to remove the pus. This time the cough became violent; my patient became cyanotic; I immediately grasped his pulse; it could not be felt; I tried every means possible to revive him, with no result; he was dead. I was unable to hold an autopsy and can account for his death to shock only, produced by a rupture of liver attachments, with a flow of pus and water into the abdominal cavity, superinduced by the cough.

The points of interest in this case, gentlemen, must be very apparent to you. Death might have ensued from several factors; firstly, from asphyxia or drowning the patient by irrigation; secondly, from shock resulting from a rupture of adhesions between the liver, abdominal wall and diaphragm. Another cardinal point is the danger of delay in making an

early incision, to prevent a communication with the bronchial tube. Once this communication is formed the graver the patient's condition becomes. The constant passage of septic material through a lung, no matter how healthy, must leave destruction in its wake, and should we succeed in effecting a cure of the primary and graver trouble, we leave a suitable nidus for the propagation of the tubercle bacillus. I feel confident that my patient suffered from such a trouble.

The conclusion I draw from this case is: All suspected cases of liver abscesses should be explored early; a negative result will not increase the danger of the patient, a positive one will surely be of inestimable benefit. If pus is located an early incision should be made and the cavity thoroughly evacuated. If a communication has already formed with the bronchial tube, irrigation should never be practised, but in its place the cavity should be constantly packed with iodoform gauze. The latter will absorb the pus and disinfect the cavity and the patient will be spared the danger from which my patient died.

### Society Reports.

#### ORLEANS PARISH MEDICAL SOCIETY, LA.

MEETING OF APRIL 29TH, 1893.

The following is the discussion of Dr. Bloch's paper on "Hepatic Abscess" (see page 205), the President, Dr. De Roaldes, being in the chair.

*Dr. Bloch* said that the cavity was very large; the patient was getting rapidly worse, and when first seen death



seemed to be a question of a few days. An operation was imperatively demanded.

*Dr. Chassaignac* said: The case impresses one important fact—namely, that the patient is not entirely out of danger even when the pus escapes freely through the lung. If *Dr. Bloch* had continued to pack the cavity with iodoform gauze instead of injecting a liquid, the patient would have made an uneventful recovery. I do not see how a little coughing could tear open such firm adhesions as must have existed in a case of such long standing. I disagree with *Dr. Bloch*, however, in attributing death to the escape of liquid into the peritoneal cavity. I cannot realize how the introduction of a comparatively small amount of warm water into the peritoneal cavity could give rise to fatal shock. In these days of abdominal surgery, we drench the cavity with warm water without shock resulting.

*Dr. Sexton* said that an abscess of the liver may open in several different directions:

It may discharge into the stomach, the intestines, through the diaphragm and the right lung, and it has been known to burst into the pericardium. It is not improbable that the injected liquid might have found its way into the pericardium in *Dr. Bloch's* case, for the heart stopped before the respiration. We need not be surprised at the fatal result in *Dr. Bloch's* case; most of *Dr. Sexton's* cases had died. Those of his cases that recovered were usually superficial abscesses of the left lobe; the large abscesses of the right lobe were generally fatal. He has a case now under treatment in which the abscess was in the right lobe, and was quite large. He made an incision about four months ago, between the fifth

and sixth ribs, and evacuated about two quarts of pus. He practised irrigation, and passed a drainage tube through the opening. The cavity shrunk up so much that the tube could no longer be introduced. The man's wife has for some time performed the irrigating. The patient is now strong enough to come to the doctor's office. He has gained fifteen pounds in weight. *Dr. Sexton* condemns trephining of the ribs as a routine practice in abscess of the liver for the following reasons: necrosis of the exposed ends of the ribs is bound to take place; thus a new disease is added to the old one. Furthermore, pus is apt to be absorbed through the cancellous tissue of the bone. Second, the traumatism incidental to the operation complicates the case; third, the sharp ends of the rib after the operation act as an irritant to the surrounding soft parts. *Dr. Sexton* has now in his service in the Charity Hospital a man whose rib has been resected for empyema. The empyema is well, but the man wants to have the necrosis attended to. Where practicable, a free incision in an intercostal space is to be preferred to resection. Last year he had a case of superficial abscess of the left lobe that was working its way to the surface; the diagnosis was very easy. In order to help the pus to reach the surface, he directed the patient to lie always on his stomach. He did this for awhile, and his condition was all that could be desired; but he became tired of lying on his belly all the time, and he changed to the dorsal position. The pus infiltrated the deeper parts of the liver and the man died.

*Dr. Bruns* said that many persons imagine that an examination of the pus

from an hepatic abscess can reveal its source. That is a fallacy that ought to be done away with. Pus from a liver is just the same as any other pus.

*Dr. De Roaldes* did not think that the injection of warm water into the peritoneal cavity could have caused death from shock. During the Franco-Prussian war, while he was a surgeon in the French army, *Dr. Robert*, now practising in Pau, was abandoned at Amiens, after the battle of Sedan, as unable to continue in service on account of sickness. Subsequently his old teacher, *Dr. Moutard-Martin*, diagnosed a hepatic abscess. The abscess was opened with a free incision, and irrigation practised. During the irrigations the doctor frequently spat up mouthfuls of injected liquid. *Dr. De Roaldes* saw *Dr. Robert* two years ago; was then a healthy man, and did not at all look as though he had once been regarded as a hopeless invalid. In those days resection of the ribs had not become popularized. Altogether *Dr. De Roaldes* had treated about thirteen cases; of these, only two recovered. One of the successful cases was a vegetable dealer, of strong build. He resected one and one-half inches of rib, which afforded free drainage; but he afterward had to treat the necrosis of the exposed ends of the rib. In the other case the abscess was opened with the galvano-cautery, and simply irrigated. In another case, in consultation with *Dr. Gaudet*, the abscess was opened with the galvano-cautery and the cavity packed with iodoform gauze. In a case that he saw with *Dr. Renshaw*, of this city, the abscess was opened and irrigation practised. One day while they were irrigating, some liquid came out that had not gone in; the patient's wife

recognized it as some broth that he had swallowed a few minutes before. He also vomited some carbolized water and had a diarrhœa of carbolized water. Later, a solution of some aniline-dye was injected, and the man vomited some of the colored liquid, and had a colored diarrhœa.

*Dr. Matas* said that the subject was one of unusual interest to him on account of the rather large number of cases that had come under his observation. When he stated at the last meeting of the State Medical Society, in 1892, that he had treated more than twenty-five cases since 1880, some surprise was caused by the statement. *Dr. Matas* was not able on that occasion to state the exact percentage of mortality or of recoveries because he had not yet tabulated and analyzed his cases, but he intended to do this fully in a future paper, and the results, he thought, would show a positive gain in the percentage of recoveries since the adoption of modern surgical methods. His ideas as to the prognosis of hepatic abscess had been positively changed for the better since his student days. When he was a resident student at the Charity Hospital thirteen years ago he had been impressed most unfavorably with the career of these cases, so that he had begun his practice with the conviction that the diagnosis of hepatic abscess was almost as bad as a patient's death warrant. The unfavorable results then were due in his opinion to the extreme conservatism of the times, which caused the practitioner to avoid an active surgical interference. The patients were treated in the medical wards and repeated aspiration with some modifications was the rule. The result was protracted hectic,



increased loss of liver substance and final death from marasmus. Operation by incision, if performed, was always done late, after all other measures had been exhausted and the patient was reduced to the most unfavorable condition for true surgical interference.

He thought that he had met with all the classical and typical conditions of hepatic abscess and many others that were not typical. He had not met with an accident such as recorded by Dr. Bloch. In abscess which had not burst into the bronchi he thought irrigation was certainly indicated and free from bad consequences. In the liver it was not as in the pleural cavity, where injections with even sterilized water had been followed by disastrous and even fatal consequences. He could not believe that death had been caused in Dr. Bloch's case by the escape of some of the injected fluid into the peritoneum, because the accidental escape of the hepatic pus of tropical abscesses without fatal results had been recorded; especially had this been noticed by the French, who, in their recent and extensive experience in Anam and Cochin China, had learned to practise the early evacuation of hepatic abscess by incision, without waiting for adhesions to form.

He, himself, made it a practice to wash out the abscess cavity thoroughly, and for this purpose always endeavored to gain free access to the interior of the cavity by free incision. He has at present in one of his wards in the Charity Hospital a case of enormous abscess of the right lobe of the liver, which illustrates his usual practice. In this case a free incision was made in the right hypochondrium, which allowed a good in-

spection of the interior of the cavity and revealed an anfractuous surface lined with partially detached and disintegrating sloughs. During irrigation, with a hot dilute solution of peroxide of hydrogen (a hot solution of common salt is used very frequently), the interior was swabbed and scrubbed carefully with a large mop of absorbent cotton or sterilized gauze held in the bite of a long hysterectomy forceps. This served the purpose of a safe blunt curette. It is necessary to do more than simply evacuate the pus; we must scrub away the partially detached masses of sphacelated tissue that line the cavity and which can never be expelled by simple irrigation through a tube, unless this be done by a long and wasting suppuration. In this particular case, there was a long history of protracted hectic, and dysentery.

The patient was marasmic to an extreme degree. Dr. Mataseven hesitated as to the propriety of any operation. Still he felt it his duty to give the man a chance, and as he appeared to stand the anæsthetic (ether) better than was anticipated, he treated the abscess in the usual way. The right lobe reached the crest of the ilium, and over three quarts of pus escaped through the abdominal incision. After swabbing the interior with a cotton mop the cavity was packed thoroughly with iodoform gauze (five per cent.) saturated with an emulsion of iodoform and glycerine, five per cent. The external dressings consisted in a heavy layer of bichloride gauze covered with absorbent cotton and held in place by a broad roller-bandage. The patient rallied perfectly from the operation, much to the operator's surprise; but the



dysentery returned, as frequently occurs in these cases, but was checked finally. Over three weeks have elapsed since the operation, and the abscess is becoming smaller every day; the appetite has returned; there has been no fever; but in the last twenty-four hours a diffuse lymphangitis of the right foot and leg has set in which it is feared will alter most unfavorably the patient's prospects. Dr. Matas had tried the new antiseptic, *alumna*, in this case. He was not dissatisfied with the iodoform emulsion which he always used in systematically packing the cavity, but he thought that he had here an excellent case in which to test the reputed pus-inhibitory properties claimed for this agent. The *alumna* was used in glycerine solution (five per cent.), with which the cavity was freely irrigated before packing. These irrigations were made daily for a week, and were perfectly well borne by the patient. There was no irritation, and Mr. Lovell, the interne of the service, who conducted the after-treatment, was well satisfied with it, believing that the dressings were less soiled with its use than with solution; still it is difficult to estimate the comparative merits of a new agent in one case.

What Dr. Matas desired to emphasize most was the *early surgical* treatment of hepatic abscess, and by this he meant free incision; blunt curetting (scrubbing), irrigating, and thorough antiseptic packing. This is the ideal treatment applicable, because it converts an internal abscess into an open wound.

An incidental question is that of resection, or, rather, the resection of one or more ribs in order to gain free access to the cavity. This procedure should not

be arbitrarily or unconditionally condemned. There are cases in which it is indicated, and others in which it is not. We should be guided by the condition of the abscess and of the patient. He recalled a case that came under his observation not long ago. The patient was a man from Honduras. He had a large dysenteric abscess of the right lobe, which pointed below the ribs. It was simply incised, irrigated, scrubbed and packed. One year after, the same patient came with another abscess, but this time it involved the convexity of the liver, and Dr. Matas was compelled to resect three inches of the sixth rib in order to open a free avenue into the cavity. The patient again recovered, and he did not have necrosis of the exposed ends of the rib, nor has this been noticed in any of his cases. In another case, which he treated with Dr. Veazie, the liver retracted under the ribs after a simple incision in the hypochondrium; and in order to pack the cavity thoroughly he resected four inches of the right costal arch and made thereby an osteoplastic flap which allowed a free exposure of the hepatic cavity. Dr. Matas is opposed to trephining the ribs, because it is easy to injure the intercostal vessels and nerves, and because unnecessary traumatism is caused thereby without the compensatory advantage of a sufficient opening. The ribs should be excised subperiosteally with the periostotome. The soft parts may be easily peeled off from a rib by simply passing a strong strip of sterilized gauze under the rib and moving it backward and forward in the manner of a chain saw. The denuded rib may be excised with a costotome or bone-cutting forceps, or short saw, to any desired length.

*Dr. Chassaignac* said he wished to emphasize one or two points. The location of the abscess has to guide us in deciding upon a resection or not. The late Dr. T. G. Richardson was convinced of the importance of having a large opening. Dr. Chassaignac was formerly his student, and he had a good opportunity of observing Dr. Richardson's methods.

In one case he was not satisfied with trephining one rib, but he took out a piece of another. In this case it was easy to look into the cavity through the large opening and see large flakes of fibrin and pus attached to the walls of the abscess. Dr. Richardson passed in his finger and removed some sphacelated masses and flakes of pus that a stream of water could not dislodge. In those days gauzes were not much used. It was Dr. Richardson's custom to allow some of the antiseptic solution to remain in the cavity after irrigating it. He often closed the opening with bandages, which were renewed every day. Some of his cases made remarkable recoveries.

*Dr. Bloch* said that he did not deprecate irrigation of itself; he deprecated its use when there was a free opening into the bronchial tubes. While he was a resident student at the Charity Hospital he took notes on eight cases of abscess of the liver. In two cases the abscess was opened in the middle line, a little below the ensiform cartilage; they got well. In the other six cases the abscess was seated in the right lobe; resection was resorted to and the patients all died.

*Dr. Sexton* said that the ribs and intercostal spaces vary in different individuals; in some persons the ribs are

close together, in others they are far apart. The text books advise, when the abscess has to be reached through the ribs, to open between the sixth and seventh, or the seventh and eighth ribs in the axillary line. Here we can easily feel the ribs and judge of the width of the intercostal space. In his case, now convalescing, he felt that there was plenty of room, and he did not resect. He thinks it is bad surgery to resect where the intercostal spaces are wide.

*Dr. M. J. Magruder* didn't think it always necessary to resect a rib even when the abscess had to be opened above the lower border of the ribs, and mentioned three cases he had treated by simple free incision between the ribs, two of which made good recoveries, and the third is now under treatment and doing well. In two of these cases more than a pint of pus was evacuated, and in the other about ten ounces. In none of these cases was the cavity packed. Two large drainage tubes were introduced and the cavity irrigated daily with warm 10 per cent. solution of hydrogen peroxide. Two of these cases occurred in the same person, who had a third one opened just below and an inch to the right of the ensiform cartilage. One week after this third abscess was opened there was a profuse discharge of bile, which continued several days, but diminished as the cavity filled up and finally ceased, the patient making a good recovery.

*Dr. Matas* said that Dr. Sexton was in error in regard to danger of wounding the pleura while excising a rib. The danger of pneumothorax had been greatly exaggerated and this fear had been one of the drawbacks in attacking abscesses of

the convexity. When the abscess involves the upper surface of the liver, the inflammation causes a diaphragmatic pleurisy, which, together with the rise of the diaphragm from the hepatic tumefaction, causes an early obliteration of the lower pleural pouch. When a knife is thrust through an interspace, it cannot open the pleura because adhesions have caused a firm agglutination of the visceral and parietal layers. Godlee, in his lectures on hepatic abscess, some years ago, showed that this was the condition. The incision should always be made below the line of dullness.

The size of the opening should be regulated by the size and depth of the cavity. In regard to the danger of allowing micro-organisms to enter with the atmosphere into the abscess cavity, he thinks it is far better to treat these abscess cavities by free and thorough evacuation of their contents and rely upon subsequent antiseptic packing than to allow the same micro-organisms to pass through a simple canula into an inaccessible cavity, where they may develop with impunity in the retained secretions and sloughs. Insufficient opening means sepsis; with the open method there is no hectic or sepsis.

Dr. Bruns said that he knows little practically about the subject, since his special practice has drawn him away from general surgery. He was contemporary with Dr. Matas in his student days at the Charity Hospital, when the treatment of hepatic abscess was revolutionized. In those days the standard treatment consisted in aspirating with Dieulafoy's aspirator and then pumping a solution of carbolic acid back into the abscess-cavity with the aspirator in its unclean condition. Under this treatment,

it was quite the proper thing for the patients to die, which they all did. The late Prof. Richardson is entitled to great credit for insisting on the abolition of this deadly treatment.

#### SALICYLATES IN RHEUMATISM.

In a recent issue of the *Therapeutic Gazette* the editor writes:

There are but two points in regard to the use of salicylates in rheumatism which, we think, should be particularly emphasized, and these are: 1, that the physician, after once deciding to administer these remedies, should give them in large doses or not at all,—that is, to use no less than 40 to 80 grains a day; 2, that if, after administering the drugs in this way, no amelioration of the symptoms of any note has occurred at the end of four or five days, it is useless to continue this line of treatment, as little good will be exercised over the rheumatic process, and much harm will be done by saturating the patient with such irritants to the kidneys and stomach as are the class of the salicylates.

#### CANNABIS INDICA INEBRIETY.

In an interesting paper read to the East India Association on April 20th, Brigade-Surgeon Pringle stated that of the admissions to lunatic asylums in Bengal during the past two years, where the course of the disease could be traced, the percentage of cases due to ganja or India hemp was 53 per cent. of the whole number of admissions. The author advocated somewhat similar legislation to that existing in Egypt and Turkey, amounting to a practical prohibition of the common sale of the drug. In Greece, the consumption of ganja is prohibited in cafes and other places of entertainment.—*British Medical Jour.*



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BALTIMORE, JULY 1, 1893.

**Editorial.**

## INDEPENDENCE OF THOUGHT.

In a recent publication by Dr. Frank S. Billings, containing his own observations on certain cattle diseases, the author makes the following terse and timely remarks, which are worthy of consideration by every physician:

We are all liable to error. Nevertheless, after weighing all the evidence, our own conclusions must be our infallible guide in all matters. The great trouble is that the majority of the human race have no evidence of their own by which to weigh that of others. They blindly accept the "has been" because of the supposed sanctity of age and its authors. Those who can observe acutely the phenomena of nature and draw conclusions that will stand the test of time have been and still are rare productions in the march of human progress. Whether right

or wrong in my conclusions time alone will tell. One thing is sure, that is, that as every other man, I have no other light than that of my own intelligence to guide me. The work of others can be but a reflected light by which each of us may strengthen himself in the pursuit of knowledge. Unfortunately, only too many find the greater portion of their intellectual light in the transmitted reflections of the past. As the heat of the sun of yesterday aids that of to-day in developing our growing harvest, so the reflected intellectual lights of the past add warmth and strength to our own endeavors; but as yesterday's sun also adds strength and vigor to the weeds which we cut down and they dry and wither in to-day's sun, so the light of our ever increasing intelligence must cut down the weeds in the transmissions of past authorities and cause them to wither on the wayside of human progress.

He who does this lives to-day, though he dies to-morrow. He is no disrespecter of the great authorities of the past. Their reflected light is the oil which makes the lamp of his own intellect burn all the brighter. The wick of past authority constantly needs trimming. Only the lamp of universal truth, filled droplet by droplet with the oil of knowledge, drawn from Nature by the laws of investigation, burns constantly on the altars of human advancement. The flame has never yet gone out, though at times the wick has become thickly crusted with accumulated ignorance, or bitter errors, due to the sanctity which unobserving man has had for dead authority. But still the flame flickered and gave some warmth; and anon comes an Aristotle, a Hippocrates, a Galileo, a Luther, a Boerhaave, a Hun-

ter, a Bichat, a Newton, a Darwin, a Virchow, a Koch, a Pasteur, a Franklin or an Edison, and with one fell stroke the crust of superstitious reverence for authority is knocked heedlessly to one side, and again the lamp of truth burns and its warmth radiates through the nations, once more replenished with fresh droplets of the oil of knowledge wrung from nature's fountains by the intellectual giants of a living present.

Such has been, is, and will continue to be, the history of the medical as well as all other branches of human knowledge.

Beware! Let us not bow down in holy reverence before any "strange god" erected by our own ignorance and assert he and he only is an authority. Every man must be his own authority unto himself. Otherwise the world would die of intellectual dry rot ere another ten years had passed over our heads.

It is this "intellectual dry rot," this respect for and leaning on some other man's light rather than our own, which is the cause of all this confusion as to the natural classification of infectious diseases. I use the word "natural" purposely. All artificial classifications are but "intellectual dry rot." Read the history of medicine and the great artificial "platforms" on which diseases have been piled up in classified order in the past, if any reader doubts. Science is not art. Learn that lesson once for all and you will learn the first great principle necessary to become an investigator of natural phenomena. Science is method. Science is the methodical study of nature's methods, in order to apply them to human necessities. If the result be artificial it fails. If it be a simple, di-

rect repetition of nature it succeeds and becomes a beacon light to further research in the same direction. The method of application is the art, but not the method itself. If the method is natural, then success follows. If artificial, it is unnatural, and failure, partial or total, results. That is a repetition, but not an unnecessary one. "Look more to nature than to the authorities" should be the rule of all true students. That is the inductive method which has led to all our modern acquisitions of knowledge, and the gradual adaptation of natural forces to our necessities. The deductive method may be said to be the "weeder" that subjects the remitted results of the past to the living sun of the present. Only the true grain stands the tests.

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#### THE ORLEANS PARISH MEDICAL SOCIETY.

We take pleasure in presenting to our readers the excellent report of the Orleans Parish Medical Society of Louisiana, received through the kindness of the Secretary, Dr. Augustus McShane; and we hope to give regular reports or abstracts of its proceedings, with original articles, in the future.

Apart from their intrinsic value, these reports will be profitable to our readers in that they contain extensive observations by able physicians upon classes of disease with which our practitioners only occasionally meet.

The paper of Dr. Bloch, on Hepatic Abscess, with its discussion, will, we believe, make the present issue of our JOURNAL especially interesting to our readers.

**Reviews, Books and Pamphlets.**

*Constitutional Syphilis*; by OSWALD ZIEMSEN; published by H. K. Lewis, of London.

This is an admirable little treatise in which the author observes the golden rules for the publication of an article: 1st, He has something to say; 2nd, He says it concisely and attractively; 3rd, He stops when he has said what is necessary. The extensive and varied experience of the author in the treatment of constitutional syphilis will entitle him to the confidence of the profession. His presentment of the varied methods of treatment, with comparative results, makes the little work both attractive and practical.

*The Transactions of the Fourteenth Annual Meeting of the American Laryngological Association*; held in the city of Boston, June 20, 21, and 22, 1892.

Before us in a neat cloth binding. It contains a well-merited obituary notice of our lamented professional brother, Dr. Frank Donaldson.

*A Book of Outdoors*; "Outdoors" is the title of a refreshing little book which is a pleasure to read. The covers are in ten water-colors, and inside are articles on Lawn Tennis, by F. A. Kellogg; Yachting, by George A. Stewart, successor to Edwin Burgess; Cycling, by Julian Hawthorne; Football, by Walter Camp; Baseball, by J. C. Morse; Horsemanship, by H. C. Merwin; Rowing, by Benjamin Garно; Canoeing, by C. Bowyer Vaux; a collection of authoritative articles on healthful outdoor pleasures, illustrated by Copeland, Beales, Galla-

gher, Young and Shute. This book, published by the Pope Mfg. Co., of Boston, for the benefit of the Columbia bicycle, contains articles without any advertising in them. Sent by mail to anybody for five two-cent stamps.

**Medical Progress.****VAGINODYNIA—PERINEAL SPASM.**

E. F. Frost (*Medical Record*, April 8, 1893) makes a distinction between this condition and vaginismus, and states that the latter trouble concerns simply the introitus vaginæ, while vaginodynia is a spasmodic affection of the whole vaginal canal—the anterior and posterior vaginal walls; the tissues of the cervix uteri, and the perineum.

The condition appears among both married and single women, and is almost always associated with a neurotic diathesis.

The writer has seen a few cases only in which the disturbance arose in patients who did not have such a temperament, and these cases were due to traumatism—too severe manipulation in making a vaginal examination, and too strong applications to the uterine cavity. Careful physical examination in the majority of cases fails to discover a cause for the spasm, and it is, therefore, ascribed to emotional conditions—a reflex neurosis. The clinical history of vaginodynia is that of a sudden attack of neuralgic pain throughout the female reproductive organs, without apparent adequate cause; attacks are severe, with sharp lancinating pains so intense as to cause such agony that the physician is summoned in great haste. If left to itself the attack



will linger for several hours; the pains will gradually leave, and the patient fall asleep from exhaustion. In the diagnosis of this condition we must differentiate between vaginitis, cystitis, retention of urine, passage of a renal calculus, coccygodynia, dysmenorrhœa, and neuralgia of the rectum or ovary. The most difficult differentiation is to diagnose between vaginodynia and vaginismus—the real difference consisting in the location and extent of the spasm.

The treatment consists in relaxing the perineal spasm, and the first measures likely to be employed by the physician may be the administration of morphia, ether or chloroform, to control the urgent symptoms; but if the exact nature of the trouble is known the most successful plan of treatment is to introduce the index finger and middle fingers into the vagina, and with the thumb on the outside as a fulcrum, pull the perineum backward toward the coccyx. The pressure should be maintained for from ten to fifteen minutes, or until the perineal muscles are tired out.

The relief experienced by the patient is instantaneous. Other periodic attacks are likely to follow after a few days, or possibly in a few hours. During the intervals between these attacks certain drugs may be useful, the writer having found the fluid extract of conium, and fluid extract of belladonna, to serve him the best. It is the belief of the writer that this perineal spasm is often the most disturbing symptom in many cases of dysmenorrhœa.

#### EPILEPSY A BAD HABIT OF THE MOTOR-NERVES.

This interesting view of epilepsy is ably presented by Dr. Hockenberry in

the *Medical and Surgical Reporter*, June 24th. He holds that in the establishment of all vices (rage, drink-habit, sexual excess, epilepsy) the steps are the same, the congenital predisposition, the first indulgence, the increased predisposition, until the man becomes a slave to vicious habit, with no strength to resist the prompting of his evil nature, that is, the impulse sent out from a perverted nerve centre.

Such an one has not acquired any new powers of mind and body; it is but a perversion of his normal attributes; a disordered function of certain centres of nervous matter that are the seat of psychological acts. So with a class of physical diseases to which epilepsy belongs; there is no change in tissue structure, but a perversion of the functions of normal tissue, of nerve centres that generate, that direct, that co-ordinate motor impulses. Epilepsy is a functional and not an organic disease. As yet, no characteristic morbid change of tissue has been found to accompany this. It is not probable that the time will ever come when its morbid anatomy will be known—when, by microscopical examination or chemical analysis, there can be detected that difference in nerve-cells by which is distinguished a greater or less power of receiving or generating nervous impulse.

Epilepsy is a "fit habit." The motor centres have from time to time indulged in independent, irregular and meaningless actions, prompted by some reflex irritation, until such motor debauch has become habitual. There has been, perhaps, in most cases, a hereditary predisposition; an inherited tendency from parents who have been afflicted with one

or more of the various neuroses of the body, or who have been slaves to immoral habits of passion, emotion, or appetite. These bring children into the world with a predisposition to one or more of the various neuroses or vices. It may be epilepsy; it may be dipsomania; it may be kleptomania.

The recurrence can only be prevented by the avoidance of exciting causes.

A peculiarity of epilepsy and also sick headache, which is of near kin, is that following an attack of sickness there is a period when exposure to those influences which have brought on an attack may be indulged in with impunity. The writer, speaking from personal experience, says, "that while the indulgence in good living is very likely to be followed by sick headache, at no time can he so safely eat of the richest food, as the day following a headache."

This is but additional evidence of the analogy to immoral habits. The safest time to oppose a passionate man is after he has indulged in a fit of anger. The drunkard is most able to resist temptation after recovering from a debauch. The libertine most virtuous after a period of sexual indulgence.

The reason of this is quite apparent. The centres of emotion, of appetite, of motor impulse having for a time been unduly stimulated, are in a condition of exhaustion, and what seems to be resistance is after all but a lack of strength to respond to the stimulus.

Could such a state be kept up it would be an easy matter to be virtuous and to be temperate.

The treatment is to brace the general system, and to avoid the exciting causes, especially through the development of

will-power and self-control. Routine use of drugs for long periods is questionable. The patient once epileptic, like the patient once a drunkard, must live forever afterwards on his guard against exciting causes. As the time never comes to the man who has been addicted to intemperance that he may become careless when exposed to temptation, neither does it come to the epileptic when he may neglect the observance of proper hygienic precautions. It may have been one year, it may have been ten years since a fit occurred, each year lessening the danger of return; but never the time that this is altogether removed. In a certain sense an epileptic is cured when he has recovered his usual health after a convulsion; but in that the danger of recurrence is removed he is never cured.

#### DANGER FROM AN UNHEALTHY MOUTH.

In the *Texas Sanitarian*, June, an Austin dentist writes as follows: It is said that a distinguished specialist of Posen has occupied himself with this subject, and mentions that loss of appetite, nausea, and general ill health may be brought about by improper attention to the mouth, causing a chronic state of putrefaction; the products being absorbed by the mucous membrane, with serious results to the general health. He was able to restore a patient by nothing more than properly cleansing the mouth. It has also been ascertained that the condition of the oral secretions and caries of the teeth act in other ways. Examinations of nine hundred and eighty-seven children in this way demonstrate that ninety-nine per cent. of all those suffering from caries of the

teeth were affected with putrefaction, swelling of the lower glands, etc., of which no physician would be able to make a diagnosis.

Dr. Miller, of Berlin, examined one case from which there was an unpleasant odor, to determine how many bacteria may be in the human mouth at one time. He found that there were millions of germs. Of these a large number are swallowed at every meal-time, and in persons predisposed exert a malignant effect upon the general health. He cites a significant case which occurred in Berlin. James Isereal, who has done so much work in this direction, discovered in one lung a very small body not much larger than the head of a pin; upon examination, he found it was dentine broken off from a root.

Every person should have the mouth examined by a competent dentist semi-annually. If the teeth are decayed, they should be filled; all badly diseased roots, especially if ulcerated, should be removed. And all stain or tartar which has accumulated on the teeth should be carefully cleansed off, and the teeth polished thoroughly, a suitable astringent wash prepared for use twice daily. And in this connection let me say a word about the use of the tooth brush. The brush should not be used crosswise over the teeth, but by gentle half rotary motion, from the gums to the cutting edge of the teeth, careful not to use too much friction, just enough to remove all particles of food or other extraneous matter, which might cause fermentation.

#### PRECOCIOUS DENTITION.

In the *Amer. Jour. Dental Science* the following vigorous statements are quoted

from an article by Dr. Barrett in the *Dental Practitioner and Advertiser*:

If the teeth which should mark the advent of the epochs in man's life are erupted prematurely, and in advance of the periods which they were properly destined to indicate, their existence will doubtless be brief, for the ripening of the other functions upon which their nutrition and consolidation depend is necessary for their support. The teeth that are occasionally found in the mouth at birth are usually soon lost. The man only is the perfect man in whom there is even balance of the functions and organs. Progression must be synchronous throughout. Undue precocity is as much a diseased condition as retardation. If it be confined to a single organ or a set of organs, it means that the disturbed functional activity is due to some untimely stimulation, and that it is at the expense of other organs.

Call up from the misty past the visions of your own experience as dental surgeons and inquire if they do not in the main corroborate that which I proclaim. Summon as witness the instances that you have yourselves observed, in which teeth were cut long before the stated period for their advent, or were unduly delayed after it, and learn if their possessor had a complete and equally developed structure and if he preserved it to a healthy old age. Were there not neuroses, and an unbalanced mental condition? Was not the physical growth incomplete, the stature low and the muscular system feeble? If not, then has your experience been at cross-purpose with mine? It is only of him to whom the natural eras of life have come in their regular sequence that it can be said that his "age is as a lusty winter; frosty but kindly."



All biographical history but confirms that which I assert. Alexander the Great was said to have had teeth at his birth and he was a drunkard and a neurotic. Cæsar was born with teeth, and he was an epileptic. Richard the Third had teeth thus prematurely developed, and he was humpbacked. Where are all the child-geniuses that have astonished the world? Their flame of life burst forth with precocious brilliance, but it soon went out in death, or early blight and decay of their phenomenal powers. Chatterton, "the marvelous boy, the sleepless soul that perished in its pride," the model of all precocious geniuses, also stands as their type in premature decay. The great eras of life must preserve their relative duration, must be marked by their accompanying outward signs, or the whole sequence of life is destroyed. An irregular dental development usually means an unbalanced organization. The healthy mind is found only in the healthy body. Who will not believe that Carlyle might have been capable of even greater things, had not his digestion been ruined by injudicious dieting in his youth, feeding with solid food before his teeth gave indications of the advancement of his digestive functions.

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### Medical Items.

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Two Girls—"Please sir, do you keep excursion pills?"

Chemist (equal to the occasion)—"Yes, we have some very fast ones."—*Ex.*

We are informed on excellent authority that Dr. Robert B. Morison has resigned his position in the Department of

Dermatology at the Johns Hopkins Hospital and Dispensary.

The third annual meeting of the American Electro-Therapeutic Association will be held in Chicago, September 12, 13 and 14, at Apollo Hall, Central Music Hall Block. Members of the medical profession interested in Electro-Therapeutics are cordially invited to attend. Augustin H. Goelet, M. D., President; Margaret A. Cleaves, M. D., Secretary.

Visitor (picking up the baby): So this is the baby, is it? Bless his little tootsie-wootsies! Kchee-e-e! Watch me poke um's ribs.

The Boston baby: Mother, will you kindly inform me whether the deplorable condition of this person is due to permanent dementia or spasmodic and intermittent insanity?—*Nat. Med. Review.*

Dr. Bell (*N. Y. Med. Times*) describes a simple and painless method of removing nasal polypi. He instructs the patient to close the nostril on the unaffected side with his finger and to blow strongly through the other. This procedure brings the polypus into view. He then injects fifteen to twenty minims of a solution of tannic acid, twenty grains to one drachm of water, into the tumor with a hypodermic syringe. In a few days the tumor dries up and comes away.—*Ex.*

The students of Social Pathology in the Johns Hopkins University are in the habit of visiting each year different charitable and benevolent institutions and inspecting their methods. The following complimentary notice of the Spring Grove

Asylum is given in the University Circular for May:

The last excursion of the season was to the Maryland Hospital for the Insane on the 11th of February. We took the Catonsville train after two o'clock, and a ride of twenty minutes brought us to the gate of the hospital grounds. This is the only strictly charitable institution which is under the control of the State of Maryland, though it receives its main support from the counties and Baltimore City through a fee of \$150 per year for each public patient. The superior appointments of the institution seem to justify the general opinion that the insane should be cared for by the State rather than by the local governments. The four hundred and forty-four inmates are classified and distributed in eighteen wards. Careful attendance takes the place of physical restraint, and employment is given to divert the mind from its wayward course. Respecting the special experiences of the day, the strange sights and sounds which met us at every turn, I will not speak here except to say that many of the impressions received will not, and some can not, be forgotten.

Sound and sufficient sleep is the most indispensable of all the conditions of a sound and efficient brain. The miseries alone of the sleepless man are creditors which the most stoical may dread; his incapacities are such that great work and great success are generally as hopeless for him as the possibility of riding through the air without a balloon or wings. Ten years of such sleeplessness as some men have endured would cure the most ardent medical enthusiast in the world of his passion for the midnight oil. The greatest and highest

success in life is achieved, like the winning of a long race, by him who has the greatest staying power. What is the best of all the possible kinds of brain for a man who has to follow throughout his life an intellectual calling like that of the higher walks of medicine? It is a brain that is at once clear and strong. Undue and prolonged mental exertion in the student period may give great clearness of intellect—possibly even an abnormal clearness, but it can never give strength. Clearness without strength can no more win in the long and arduous race of life than speed without staying power can win in a foot race of ten miles. Unintelligent and impulsive medical professors—and there are many such—may urge men to competition for the highest college honors, even at the risk of a total breakdown in brain and body. Such professors are among the worst enemies young men could have, and they are among the worst enemies the medical school and the medical profession can have. What the medical profession demands is men of clear and strong intellect, full of practical resources, not mere dilettanti speculators in incomprehensible medical hypotheses. The day is the time for work, the night for sleep; sleep sound, quiet, and peaceful as death. The learned medical professor tells his students all this in his book or his lecture. But he seldom thinks of asking them to apply his lofty and ideal principles to the details of their own lives. The first thing that the world demands of professors and teachers of all kinds is that they shall practise their own principles. A teacher of physiology who encourages brain work at midnight ought to be considered insane.—*The Hospital.*

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## Original Articles.

### THE EVOLUTION OF MEDICINE.\*

BY DR. NOBLE P. BARNES,  
OF COMLY, OHIO.

Friends and classmates:—The Evolution of Medicine has been selected as an appropriate subject for this occasion, knowing that it would be interesting to journey backward on the wings of fancy, and view with the eyes of our imagination the very incipency of a profession in which we are about to be enlisted; A profession whose strides in the past century have enabled it to out-class all others; and to stand, at the present day, topmost of sciences known to humanity.

It is, indeed, most fascinating to investigate remote periods of time and col-

lect fragments from scanty resources, all of which are obscure and cloaked in the mystic maze of mythology; gradually augmented by thrilling, yet questionable, Grecian and Roman legends, sinking into the dark obscurity of the middle ages, then slowly unfolding up to the last century, when the science of medicine burst forth in almost overwhelming streams of modern copiousness.

Medical science has not been an impediment to the ever-onward march of civilization, for improvement in the removal and alleviation of disease, in the repair of injury, and in the relief of suffering humanity has during all ages progressed hand in hand with the advancement of mental and æsthetic culture; though subject through its entire course to noxious agents, such as bombastics, which in a degree have deranged its func-

\*Address delivered before the graduating class of the Baltimore Medical College, March 29, 1893.



tions, and have become obstacles to its full advancement.

It is reasonable to believe man had scarcely realized his position in life before he began discovering means for promoting the relief of pain and the cure of disease. For instance, in a solution of the continuity of the body, it being extremely liable to such injuries in the rude status of society, one, even with an exceedingly dull comprehension, would readily observe that, by exclusion of air and extraneous substances, and elevation of the affected part, diminution or removal of pain is secured; that certain positions and pressure arrest the flow of blood; and that in some conditions the application of an increased or decreased temperature gives relief and favors restoration. A rude species of surgery of this description has been found in practice in every case of a newly discovered people, even in the most barbarous status; and improvement in the healing art is always in proportion to the advancement of other arts and sciences intimately connected with the existence and welfare of the people.

As stated, the scanty historical records to which we have access are confusing and uncertain; deductions, however, from earnest investigation conclusively prove that Mother Egypt cradled the art of medicine, as well as most other arts and sciences cultivated with any marked degree of success. In the first place, we discover the art, if art it should be called, in the possession of the Egyptian priests, who were the physicians and exercised their operations mostly through the medium of the imagination; consequently the efficiency of these operations could only be in proportion to the ignorance,

superstition and extremely infantile mental condition of the people upon whom they were practised. The treatment, judging from the Mosaic writings respecting the learning of the Egyptian priests, consisted in the application of the magic arts, and impressing upon the mind of the patient the control they had over nature. Therefore the greater expertness with which these charms were employed, the better the doctor. You can imagine, then, that a magician similar to Hermann, with the office of priesthood, would, in those days, have been a glorious success. Most probably they possessed some actual information, which was with the greatest care concealed, so that they could keep the community in a state of fear mingled with admiration and reverence.

Greece next began to cultivate the arts and sciences borrowed from neighboring nations, principally from Egypt, and it became quite the fashion to travel into this country to finish the education; and after a rigid discipline of the various tedious, unmeaning solemnities, they returned, "in the spring," doctors, with a thorough knowledge of the ceremonies of evoking spirits, of incantation and the application of some external remedies, with a very imperfect idea of the human anatomy and an inadequate conception of its functions.

Not until the period approaching the Trojan war are to be found the names of actual personages who practised medicine; and the first Grecian who appears to be particularly singled out as having introduced the art of medicine into his country is the Centaur Chiron. His people inhabited the neighboring districts of Thes-saly and were the first to train horses

for riding purposes. Their warriors, mounted upon galloping steeds, with long lances vanquished every foe; hence were called the "Air Piercers" and "Centaur's." This gave rise to the present fabulous account we have of his compound form and the general erroneous idea of the people of his day who fancied the warriors monsters—half steed, half-man, having hoofs and manes, living wild among the mountains.

This Centaur Chiron lived about the thirteenth century; his home was a richly adorned cave in Mt. Pelion. Its entrance curtained by blossoming vines, surrounded by stately trees of greenest foliage, while the singing birds, the chirping squirrel, and the sweet perfume "of the most beautiful thing God ever made and forgot to put a soul into, the flower," all lent their varied charms to the situation. The low walls of the cave were decorated with relics of battle and the chase, while soft couches of bearskin, and the blazing center fire, sending its flickering rays into every cranny, gave to all the appearance of comfort and retirement. Now enters an old man with white hair and beard reaching his waist; with a bright clear eye and a firm youthful step. Taking up the golden lyre he "touched with flying fingers" and "trembling notes ascend the sky and heavenly joys inspire." "He sang of things pure, good and beautiful; of faith strong and holy; of hope bright and trustful; of love pure and mighty." This was Chiron the Centaur, the wisest of men and the teacher of heroes; who taught what was just and true, and that gentleness is greater than strength. He is celebrated not only for his superior skill in medicine, but, also, for his achievements in music, a combination

worthy the possession of any man; and, recalling the remarks made by our esteemed professor upon the therapeutics of music, we can easily understand one cause of his superiority.

Æsculapius, Chiron's pupil, is mentioned as having been the first to devote his attention more especially to medicine, and so great were his amendments to the science that after his death his countrymen bestowed divine honor upon him, designated him as the god of physics and the healing art; erected temples to his memory; and considered his origin as being directly from the god of music, poetry, eloquence, medicine and the fine arts, all of which are attributes of the great Apollo.—He was found when an infant by a shepherd and taken to the home of Chiron, where he was cared for and reared to manhood. In youth it was his greatest delight to wander among the crags and ravines collecting herbs and flowers, and studying the habits of birds. On reaching maturity he set out on his mission, and everywhere he healed, purified, raised and blessed. He was the greatest conqueror of all Chiron's pupils; but he won not by strength like Hercules, nor by guile like Jason, but by gentleness, kindness, self-sacrifice, knowledge and skill. The people held him in highest estimation, because he cured while others killed. So great became his reputation of snatching back to life those who were at death's door, that Pluto's jealousy was aroused and he began to complain that the great healer was robbing his kingdom, Hades. Jupiter hearkened unto the increasing fury of Pluto and smote Æsculapius with his thunderbolts. Thereupon the sun was veiled, and deepest mourning "was upon



the face of the earth." The flowers withered and died upon their stems, the trees drooped their leaves, and the moaning wind sang a solemn dirge among their barren branches, because the gentle physician who had cured all pain and sickness was stricken from their midst.

The custom of transmitting the profession from father to son was at this early day adopted; accordingly the sons of Æsculapius, Machaon and Podalirius, inherited the learning of their father. They accompanied the Greeks in the Trojan expedition, and are highly lauded in various passages of the Iliad for their wonderful surgical skill. Internal affections were then considered as being the direct infliction of the Deity, therefore charms played the principal roll in their treatment. They also had no inconsiderable part in the surgical operations; as when Philoctetes lay upon the cot in the tent of the kind physician, a sweet odor, like that from blooming orchards, filled the place and he slept; and men said the spirit of Æsculapius fanned him into slumber. Then Machaon, with matchless skill, dissected out the poisoned flesh from his foot, cleansed the wound, dressed it with soft linen, and immediately it began to heal.

For some time the practice of medicine remained hereditary with the descendants of Æsculapius, who received the name of Asclepiades and were the priests of his temples, three in number—Cos, Gnidos and Rhodes. Over these they presided and directed rites and ceremonies. These temples became each a sort of hospital, and being in a healthful situation with pleasing surroundings, were excellent places for rest and retirement. Besides the rudimentary treat-

ment already mentioned, stress was put upon diet, temperance and cleanliness. Thus ample opportunity was afforded for the study of morbid action and the effects of medicinal agents. Close observations of symptoms was made, which with the detailed history and treatment, were deposited in the temple on a votive tablet. These tablets were religiously preserved and must have gradually led to improvement of the art. We are informed that Hippocrates made great use of the records from the temple of Cos in writing the treatise "*Coacae Praenotiones*" which is generally attributed to him.

After a time a difference of opinion arose between the priests in control of the establishment of Cos and Gnidos, and they became rivals. The former assumed a more philosophical course, attempting to unite reason and experience; the latter were attached solely to the observation and collection of mere matters of fact. Thus we have at this early age a foundation laid for the two great sects, the Dogmatists and the Empirics, which for many years divided the medical world.

Although the philosophy of Cos was founded, for the most part, upon erroneous principles, little benefit being realized from the fallacious bases, nevertheless it caused them to exercise their intellectual powers and enabled them to reason more accurately upon medical and other subjects. Centuries passed and but meagre progress was made while the science of medicine was under the control of the priests, who practised for the purpose of maintaining their influence over the people. Fortunately this science began to be cultivated by an en-



ergetic class of persons, much more likely to induce a spirit of improvement.

It was about the sixth century when the genuine principles of philosophy were introduced into Greece. The powers and functions of the human body were examined and studied. This naturally led to inquiry into the nature and cause of disease, and the adaptation of means for its removal. Much time was required before actual advancement in the knowledge of pathology was effected; but we observe the results of a more correct reasoning, and the stronghold of mystery and superstition became weakened, if not entirely destroyed.

The renowned Pythagoras was the first of this class of whom anything, even the name, is known, and his history is enveloped in obscurity. He is supposed to have dissected the bodies of animals, in this way acquainting himself in a measure with anatomy. (It is needless to state here that some of our own class began their study of this branch in a similar manner, and our internes were particularly prone to perform autopsies upon defunct felines that would otherwise have accumulated about the hospital and boarding places.) Pythagoras instituted a school at Cortona, the first on record, which was well patronized by students from all civilized parts of Greece and Italy. He traveled twenty-two years in Egypt, obtained information from every known source and was therefore a man of superior acquirements.

The illustrious philosophers succeeding him are regarded as belonging to his school, inasmuch as they cultivated natural knowledge by observation and

rude forms of experiment. None devoted their attention exclusively to medicine, but they indirectly contributed to its advancement; preparing the way for one of those great and commanding geniuses who occasionally appear, and, with superior intellectual powers, completely revolutionize the world of science.

The Democriti were among the famous followers of Pythagoras but their reputation was gained more by the successful way in which they supported their peculiar hypothesis rather than any additional knowledge. Their favorite doctrines of elements were applied to explain the phenomena of disease and the operation of medicine. One of these philosophers is well worthy of honorable mention for the achievements he made in comparative anatomy, and e'en a rumor ran that he ventured upon the dissection of a human body.

Acron is mentioned by Pliny as being first to attempt the application of philosophical reasoning to medicine; but we have no knowledge of his history or character, nor can we discover any records of the principles he employed; and Herodicus is merited as inventor of gymnastic medicine, regarded by the Greeks as a very important branch of the art.

Up to this time only the groundwork of the vast pyramid of medicine was begun. Each generation contributed its collections to the past store and handed them down to the next; in this manner gradually fashioning the way for an individual of distinguished character and acquirements, destined to effect a complete change in his profession and to introduce a system from which grew all its subsequent improvements. This man

of unsurpassed genius and ability was the immortal Hippocrates, "The Father of Medicine."

It is a little remarkable that, notwithstanding the celebrity he attained, no accurate knowledge can be procured of his history, education or the means pursued to acquire his wonderful pre-eminence. All we can elicit is that he was brought up among the Asclepiades who superintended the temple of Cos; was a student under Herodicus; and is reputed as a lineal descendant in the thirty-third degree from Æsculapius. These circumstances naturally had the effect of originally directing his mind to the pursuit of the subject, the advancement of which he afterward so largely promoted. He also traveled much for learning's sake, and later to arrest raging epidemics. His works are numerous and interesting. Speculations and hypotheses fill his pages; and in his works we find the first trace of physiology. He appears to have had the sagacity to discover these fundamental truths: first, that "the basis of all our knowledge is accurate observation of actual phenomena, and the correct generalization of these phenomena should be the sole foundation of all reasoning." We are indebted to him for inventing an hypothesis, the principle of which he gives the appellation of "nature"—that "which influences all parts of the corporeal frame, superintends and directs its motion and possesses a kind of intelligence so as to promote all actions which are beneficial and repress those which have an injurious tendency." From the leading doctrine of Heraclitus, "that fire is the prime origin of all matter, and by the collision and peculiar combi-

nation of its particles, which are in perpetual motion, the four elements are produced," Hippocrates derived his principles of pathology and all his medical hypotheses. His favorite doctrine of the fluids of the body being the primary seat of disease became the prevailing opinion of all sects and theorists until the commencement of the eighteenth century. He considered the body as consisting of four elements combined in different proportions in different individuals, so as to produce an original dissimilarity in the constitution of each and every individual, which gave rise to four temperaments. These influenced both the intellectual and corporeal part of the person, and laid a foundation for disease independent of external circumstances; and caused these circumstances to operate in a different mode and in a variable degree in each particular individual. The combination of the four elements with the four qualities or states by which they were effected, of hot, cold, dry and moist, gave rise to the four fluids or humors of the body: blood, phlegm, bile and black bile, which primarily tended to produce four temperaments. These in their turn contributed to the excess or defect of each humor. Now, should we be permitted to judge which of these humors are in excess by the temperament or peculiar physical and mental character of an individual, we would undoubtedly think of some persons whose striking characteristics induce most people to believe that black bile is the predominant fluid of their bodies. The laity are well acquainted with the idea suggested, but do not endeavor to express it technically nor artistically. You are all more or less familiar with

their enunciations. In concluding the review of the life of Hippocrates we are warranted in saying that while some persons of every nation and age attain great distinction, whose spirits now rule us from their urns, yet there are but few whose memory is more cherished and perhaps none whose fame is established on a firmer foundation than that of Hippocrates.

It is needless to attempt even to notice briefly the progress in our science after the time of Hippocrates, to speak of its introduction into Rome accompanied by all the superstition imaginable; to take up the conditions and progress in the various countries and speak of the contributions of the Arabians and others; to visit the many and ever-increasing schools, beginning with that at Alexandria and traveling along until we find ourselves within the walls of the Baltimore Medical College; to follow the decline of medicine and the introduction of chemistry, which gave rise to another division of ideas, creating the two sects, the Galenists and the chemists; to mark the appearance of new diseases, the rise in the study of anatomy under Mondini and its further development under Fallopius, Eustachius, Malpighi and others.

How much more impossible is it to name the various builders of the pyramid of medicine, to dilate upon the history, education, opinions and practice of Galen, Sylvius, Willis, Hoffman, Brown, Darwin, Harvey and others; to take up each individual train of thought and solve the difficult hypotheses, speculations and methods leading to discoveries; to bring it down to a later date of medical journals and societies with the

division into the several specialties which bring about an improvement in every branch; and still later the wonderful change and total obliteration of the so-called idiopathic diseases by the progressive germ theory. It is useless to mention the many skilled artists of the present century whose works are studied by the rising generation and whose dust, after cremation, being scattered to the four winds, shall reach the shores of every nation; so shall their doctrines be spread broadcast throughout the entire universe.

The crude material, then, that Hippocrates developed into the proportions of a science, which was neither well defined nor harmonious, was handled and fashioned by the sons of all civilized nations, our own being second to none; and the achievements of generations added to those of preceding generations gradually reared the pyramid of medicine to the magnitude it shows in this century, which will have contributed more than all others combined, even if no more be taken into consideration than the great trio discovery of vaccine, by which the sword of that death-dealing disease, variola, was dulled into submission; of anæsthesia, that "God-send" to mankind; and of antiseptis, begun by the celebrated Lister and improved by more modern surgeons. We are proud to have received instructions from one whose original ideas and earnest teachings have placed us, we believe, on a higher plan than the majority of surgeons.

While we would have the people think that there are few things we do not know, yet to the future remains an abundant opportunity for discoveries and improvement. By ob-



servation we know our senses are improving; as the maxim tells us, "we are growing weaker and wiser;" then from the development of these are to come the great inventions and discoveries of the future. And why should not the Columbian class of the Baltimore Medical College be participants in the searching out of specifics to counteract the various diseases as effectually as cinchona counteracts intermittent fever, citric acid the scurvy, or vaccination the small-pox.

What will be the mode of practice in 2000 A. D. is a matter of conjecture and will be left to the doctors of that age; being neither a "prophet nor the son of a prophet," I would hesitate upon entering into the discussion of that subject at this time. However, we know, even if the vices and follies of mankind are obliterated, the duties and necessities of life will, throughout all generations, be a fruitful source of ailment; but it is to be hoped that our knowledge of disease may be so extended and our powers of resistance so increased and defined that human judgment and foresight may universally be found adequate either to prevent or to relieve all diseases and maladies incident to humanity.

Let me impress upon my fellow students one important fact that may be useful to some who consider greatness out of their reach. The fact is, men who have received golden crowns of everlasting glory in our profession, as well as in any branch of science, art or industry, have not been so much men of genius, as men of mediocre abilities, but untiring workers, self-reliant and persevering. It is an acknowledged fact that the state of civilization in which we live, and all that is great in morals, in intelligence, in art

or in science has been advanced toward perfection by diligent labor; and that the greatest results in life are obtained by simple means and the exercise of ordinary qualities. The open path of human welfare is along the highway of steadfast perseverance; and those who are most persevering and work in the truest spirit will invariably be most successful; "as winds and waves are on the side of the best navigators, so is fortune on the side of perseverance." It was Baccara who was of the opinion that all men might be poets and orators; Reynolds that they might be painters and sculptors. Locke, Helvetius and Diderot believed all men to have equal aptitude for genius; and what some are able to effect under the influence of the fundamental laws which regulate the march of intellect must also be within the reach of others, who in the same circumstances apply themselves to like pursuits. Then, all can acquire knowledge and display the highest virtues of life, good-sense, prudence, temper, firmness, wisdom and wealth, by labor and perseverance. We are told that "some are born great and some have greatness thrust upon them," but a purpose steadily held trains the faculties into strength and aptness like a river that gathers volume and momentum by ever flowing on.

The true man of genius is never fully satisfied with his own work. He is often tormented with a feeling of powerlessness to that which he has planned in his imagination. When a by-stander was admiring a statue which the Flemish sculptor Duquesnoy had just finished, the artist exclaimed "Ah, if you could but see the statue that is here" (touching his forehead with his finger).

Keep ever before you the fact that there is "always room at the top" and aim at perfection in all things, though in most things it is unattainable; however, those who aim at it with determination will come much nearer to it than those whose apathy and despondency make them give it up as unattainable.

The Faculty of our College: long may you continue to enjoy the progress and excellent results of the institution you have so energetically and successfully labored to bring to the front and place in advance of modern colleges.

May you ever tread "the ways of glory," "sound all the depths and shoals of honor," progress to such renown that the future shall bless your name; and as a faculty mold up such mighty efforts that our college, the belle of the east, "shall star-like rise" to the zenith of fame.

To the grand old city of Baltimore we must bid adieu, and to her daughters fair, for none more fair than they. (Yes, they are fair and, "fairer than that word," of wondrous virtues.) Sometimes "from their eyes we do receive fair speechless message." With us these gentle people's wishes are commands and their words law, for "ingenious Fancy, never better pleased than when employed to accommodate the fair;" and they give us for our pains a "world of sighs." "The wide world is not ignorant of their worth, for the four winds blow in, from every coast, renowned suitors," who for many years have considered the Monumental City as the home of beautiful women.—To all these we lingeringly say good-bye; and you, my companions, the moment soon comes when we must part. In this life may time for you a thousand blessings ripen. Ever wear the "dauntless spirit

of resolution," remembering that the "purest treasure mortal time affords is spotless reputation." Then to yourself, country, profession and God be true. and now to all:

"Farewell: a word that must be,  
and has been,  
A sound that makes us linger—  
yet—farewell."

## MULTIPLE FRACTURE OF BOTH UPPER EXTREMITIES.\*

BY WILLIAM J. TAYLOR, M. D.,

Surgeon to St. Agnes' Hospital; Assistant to the Orthopædic Hospital and Infirmary for Nervous Diseases, Philadelphia.

Margaret C., aged fifty-six years, a widow, and by occupation a monthly nurse, was admitted to my ward at St. Agnes' Hospital, on the evening of October 19, 1892, suffering from the most remarkable number of fractures, considering the amount of constitutional disturbance, it has ever been my fortune to see. She was going down the cellar stairway in the dark when she missed her footing and fell to the bottom, some eight or ten steps. From the nature of the injuries she must have put out her hands before her in the hope of breaking the fall.

She was unconscious for a short time, and was then brought to the hospital in a patrol wagon, but recovered sufficiently to walk from the wagon into the receiving ward.

Upon examination it was found that she had received a lacerated wound of the scalp, six inches long and extending down to the bone, and a deep lacerated wound of the lower lip about two inches

\*Read before the Philadelphia Academy of Surgeons, March 6th, 1893.



in length. There was a fracture of the surgical neck of the left humerus and an oblique fracture of the middle one-third of its shaft; a contusion of the left elbow and a fracture of the lower end of both the radius and ulna of the same side. There was a supra-condyloid fracture of the right humerus extending into the elbow joint, forming a T. A fracture of the upper third of the radius and of the ulna, and a fracture of the lower end of the radius. In spite of this great number of fractures and of the serious lacerated wounds she was able to walk into the hospital, and seemed to suffer comparatively little pain. Her temperature was normal, her pulse good, and there was no evidence of shock such as would have been expected from the nature of her injuries.

There was much difficulty experienced in adjusting and holding in place the different fractures, but with care and patience and plenty of plaster-of-Paris this was accomplished. Her recovery has been most satisfactory, and she has for all practical purposes full use of both arms.

Such an extensive number of fractures led me to suppose there must have been some serious lesion of the bones, but the most careful inquiries failed to give me any clue to such a state of affairs. She was a large, strong, and apparently perfectly healthy woman. She had never before had a fracture of a single bone, neither was there any history of fracture in any member of her family. She was born in Ireland, and had lived there until a few years ago, had always been in good health and a hard worker.

Dr. J. B. Hamilton has been appointed editor of the *Journal of the American Medical Association*.

An object of interest at the Columbian Fair will be an enormous microscope which is now being constructed in Munich. It will magnify 11,000 diameters, and the instrument will cost nearly \$10,000. For the purpose of illuminating the images, which will be projected upon a screen, an electric light of 11,000 candle power will be used.—*Ex.*

Saccharin is a powerful antiseptic of the mouth in weak solutions, but in strong ones it attacks the enamel of the teeth. This property of attacking the enamel seems to be due to its acidity.

Neutralized solutions of saccharin, even very concentrated, are absolutely inoffensive for the teeth, and also sufficiently antiseptic, especially against the microbes of the mouth.—*Amer. Jour. Dent. Sci.*

Seiger gives, as the cause of baldness in men, the wearing of heavy and impermeable hats, which prevent evaporation of perspiration and secretions, and to a certain extent macerate the parts. The pressure of the rigid hat band, by interfering with the circulation, is another factor in the causation of this disease.—*Medical News.*

The Imperial Health Office at Berlin has published an article stating that the comma-bacillus is destroyed in a few hours by being placed upon the cut surface of a lemon or of an orange, and that upon the external skin of these fruits they die in from one to two days. Consequently there will be no restriction upon the sale of those fruits, even if they are brought from places that are infected with cholera.—*Ex.*



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BALTIMORE, JULY 8, 1893.

**Editorial.**

## THE UNION FOR PUBLIC GOOD.

The high state of organization attained in our great cities by certain agencies for evil is a standing wonder of the age and a growing menace to the life of our nation.

It has therefore been felt by many public well-wishers that a rival organization of the powers for good is greatly to be desired.

Such an organization has just been consummated for this city, and its future career will be watched by Baltimoreans with deep interest. It is believed that it will afford an agency through whose ramifications a great weight of influence can be quickly brought to bear upon our legislators and public officers, through the awakening of public enthusiasm for needed improvements or through protest against new or long-standing evils.

Although called into being by the

Ministerial Union, its present organization embraces societies of every shade of religious faith, as well as secular associations of great influence in the city. Among its members are some of our most talented lawyers, whose experience in the somewhat similar work of the Law Association will be of great value to the Union. The medical profession is well represented, both by delegates from the Medical and Chirurgical Faculty, and by outside representation. The labor organizations are among those whose co-operation has been sought and granted in this new enterprise.

It is proposed for the present to hold the union in readiness for any great occasion which may arise, rather than to force upon it any of the private tasks of its constituent associations.

The following account of the last meeting is taken from the columns of the *Baltimore Sun*, of June 20, 1893:

The Union for Public Good effected a permanent organization last night at the Young Men's Christian Association Building. It adopted a constitution and elected officers to serve until the annual meeting in November. The officers elected were: Chas. J. Bonaparte, President; Percy M. Reese, Treasurer; Rev. Dr. Tobias Schonfarber, Corresponding Secretary, and Rev. Hiram Vrooman, Recording Secretary.

The purpose of the association, as stated in the constitution, is to promote the good government, health and prosperity of the city of Baltimore; to secure useful and to prevent injurious legislation affecting its interests; to correct public scandals, grievances and abuses; to restrain all forms of vice and immorality, and to encourage the co-operation.

tion of individuals and existing societies aiming to advance these ends.

Resolutions were adopted for the appointment of standing committees on finance, membership and on grievances and abuses. The grievances and abuses committee will consider all complaints as to alleged violations of law or misconduct of public officers and will make investigations and report to the Union. A resolution was also adopted inviting affiliated societies to prepare papers one week before the annual meeting, suggesting any action on the part of the Union which the governing body of the affiliated society may deem advisable.

Any congregation or society having for its object the moral or social improvement of the community may be affiliated with the Union and be represented at its meetings by three delegates. The meeting adjourned subject to the call of the president.

#### NERVE AND SPINE INFLAMMATION AFTER LABOR.

To every practitioner this theme must be of interest, since the occurrence of severe neuritis after childbirth is, although infrequent, one of the most painful yet most mysterious and obstinate of all the disease-conditions with which he has to deal. Occurring suddenly, as it often does, in a patient who seemed to have passed through the ordeal of parturition in safety, it leads to an anxious and apparently endless lying-in, which slowly saps the energies and breaks the hope of the patient.

With deep attention therefore we peruse a monograph on this subject by Dr. Charles K. Mills, of Philadelphia, re-

printed from the May number of the *University Medical Magazine*.

After a short review of the references to the subject in medical literature, Dr. Mills takes up in order the different forms of neuritis and myelitis following labor, giving cases illustrative of each form, from his own practice and that of other observers.

The *first* form considered is "Neuritis Associated with Paralysis of the Peroneal Type." While the roots from the sacral plexus which form the sacral nerve lie on the soft cushion of the pyriformis muscle, those roots which go to form the peroneal (external popliteal) nerve pass over the sharp bony surface of the linea innominata. In labors where the head is impacted in the upper portion of the canal a long time, the pressure of the head may cause crushing of these peroneal roots, resulting in painful inflammation of the nerve and serious, perhaps prolonged, paralysis of the muscles supplied by it. Secondary implication of the cord or the opposite nerve may occur, through extension of the inflammation along the nerve-tracts.

The *second* form of inflammation considered is "Sacral and Sacro-Distal Neuritis without True Paralysis, although sometimes accompanied by Partial or Pseudo-Paralysis." This group includes certain cases (similar to others occurring in pregnancy or whenever else there is a heavy body pressing upon the pelvic nerves) in which the inflammation is less severe than in the preceding group and many of the pelvic nerves are affected, all of the pelvic contents being in an extremely sensitive state. Partial paralysis may occur, but under proper treatment recovery soon ensues.

The *third* form includes cases of "Puerperal Neuritis Due to Septic or Other Infection." Under this title are grouped those cases of isolated, diffused or multiple neuritis which are supposed to be due to infection. As they may also occur in pregnancy they are evidently non-traumatic in origin.

The symptoms come on usually in the first, second or third weeks after labor. In these cases the invasion of the nerve-tissue by septic organisms, from without or from within the body, is rendered possible by the effects of previous disease or excess, or by the exhaustion, excitement and strain of parturition. According to the degree and extent of the onslaught neuritis with or without palsy, or myelitis, or intracranial inflammation with convulsions, or psychic affections, or other brain symptoms may occur, with severe or even fatal result.

The "Neuritis and Paresis Associated with Phlegmasia Alba Dolens" is considered separately by our author as a *fourth* form of nervous disorder of the parturient, although the cases might properly be distributed among the forms already given. Several interesting illustrative cases are given at length from the practice of Dr. Anna Fullerton, of Philadelphia.

As a *fifth* form, is discussed "Puerperal Myelitis Due to Septic or other Infection." Among the cases quoted, one from the practice of Dr. Mills, presenting two myelitic attacks at intervals of several years, is interesting, not only from its connection with alcoholism, but also with reference to the belief that disseminated myelitic foci possess, in the great majority of cases, septic and infectious properties.

The treatment of these forms of puerperal nerve inflammation is succinctly presented.

The monograph is very valuable, not only for immediate perusal, but likewise as a permanent work of reference in the library.

We regret that Dr. Mills does not append his city address, but we suppose the reprints may be obtained by a letter directed "care of Editor University Medical Magazine, 214 South Fifteenth Street, Philadelphia, Pa."

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### Obituary.

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#### DR. JAMES McCANN.

We join with the profession of Pittsburgh in deploring the death of DR. JAMES McCANN, the presiding officer of the Western Pennsylvania Medical College, recently removed from the scene of his earthly labors by the hand of death.

Dr. McCann was born 57 years ago in Penn Township, Allegheny Co., Pa. After nine years of industrious self-training as school-teacher and business agent, he began at the age of twenty-two years the study of medicine in the office of Drs. Thomas and John Dickson, Jr., graduating from the Medical Department of the University of Pennsylvania in 1863. After serving for two years in the war as surgeon he began the practice of medicine. He was appointed one of the surgeons to the Western Pennsylvania Hospital, and soon afterward surgeon to the Pennsylvania, the Allegheny Valley and other railroads entering Pittsburgh.

The esteem in which he was held by the profession at large is shown by his



membership in the American Surgical Association, the American Association of Obstetricians and Gynecologists, and other important societies.

Joining with other members of the "Mott Medical Club," he organized the first medical college in Western Pennsylvania, and was elected in September, 1886, to the Chair of Surgery in that institution.

His practice was enormous, the sufferings of the poor ever appealing to his sympathy.

He died after thirty years of untiring professional industry, of monumental achievement; leaving behind him an honored name, a great school of medicine, and a life-record full of kindly, skillful service to suffering humanity.

### Books and Pamphlets Received.

*The Treatment of Alcoholic Inebriety*; by FREDERICK PETERSON, M. D., Instructor in Nervous and Mental Diseases, College of Physicians and Surgeons, New York; Professor of Nervous Diseases in the University of Vermont. Reprint from *Journal American Medical Association*, April 15, 1893. Chicago, Ill.

*The Cure of Complete Prolapse of the Rectum by Posterior Proctectomy*; by JNO. B. ROBERTS, M. D., Philadelphia, Pa. Reprint from *American Journal Medical Sciences*, May, 1893.

*Colotomy*; A Clinical Lecture on Diseases of the Rectum, delivered at the New York Post-Graduate Hospital; by CHARLES B. KELSEY, M. D., Professor of Diseases of the Rectum in the New York Post-Graduate Medical School.

Reprint from *Therapeutic Gazette* May 15th, 1893. Detroit Michigan George S. Davis, Publisher, 1893.

*Metatarsalgia* (Morton's Painful Affection of the Foot); with an account of six cases cured by operation; by THOMAS S. K. MORTON, M. D., Professor of Surgery in the Philadelphia Polyclinic, etc. Reprint from Transactions of the Philadelphia Academy of Surgery, Philadelphia, 1893.

*Neuritis and Myelitis and the Forms of Paralysis and Pseudo-Paralysis following Labor*; by CHARLES K. MILLS, M. D., Professor of Diseases of the Mind and Nervous System in the Philadelphia Polyclinic, etc. Reprint from *University Medical Mag.*, May, 1893.

*Methods of Precision in the Investigation of Disorders of Digestion*; by J. H. KELLOGG, M. D., Superintendent of Sanitarium at Battle Creek, Michigan. Modern Medicine Publishing Company, Battle Creek, Mich., 1893.

*Laparotomy and Removal of Cystic Tumor (Cysto-Adenoma) of Peritoneum*; Formation of Artificial Anus; Subsequent Laparotomy and Resection of Colon; Closure of Artificial Anus; Recovery. By W. PAGE MCINTOSH, M. D., P. A. Surgeon, Marine Hospital Service. Reprint from the *Amer. Jour. Med. Sciences*, May, 1893.

*Reports from the Consuls of the United States*, June, 1893. Commerce, Manufactures, Etc. Washington: Government Printing Office, 1893.

*The Clinical Value of Repeated Careful Correction of Manifest Refractive Error in PlasticIritis*; by CHARLES A. OLIVER, M. D., of Philadelphia. Reprint from *Amer. Ophthalmological Society Transactions*, 1892.

*Bulletin of the Harvard Medical School Association*, Number 4. Boston: Published by the Association, May, 1893.

### Correspondence.

#### COMPLICATIONS OF TONSILLOTOMY.

*Editor Maryland Medical Journal:*

Desiring to present an article on the subject of "Complications of Tonsillotomy" at the next annual meeting of the Louisiana State Medical Society, I would request your readers to favor me with answers to the following questions:

1. Number of cases of hypertrophy of faucial tonsils operated upon.
2. Complications occurring during these operations, stating nature of complications, and number of cases affected.
3. Method of operating in the cases in which these complications developed.

In publishing these cases, I shall omit the name of the physician who reported them, if desired.

I shall mail a reprint of the article, which I shall present at the meeting, to those physicians who send me a report of their cases, as above. Letters should be addressed to W. Scheppegrell, M. D., care of Eye, Ear, Nose and Throat Hospital, New Orleans, La.

Very respectfully,

W. SCHEPPEGRELL, M. D.

### Medical Progress.

#### ARKANSAS ELOQUENCE.

The following specimen of Arkansas eloquence is erroneously ascribed by the *British Medical Journal* to the stimulat-

ing influence of the waters of the famous Hot Springs of that State upon the medical cerebrum. We would assure our worthy contemporary, however, that the editorial mind of the "woolly West" is quite equal to such noble literary productions without other stimulus than that common to all the inhabitants of the Mississippi Valley. A perusal of others among our western medical journals will reveal to the British gaze many such able effusions.

The British commentator says:

Whatever therapeutic virtues may be claimed for the waters of Hot Springs, in Arkansas, they seem in some cases to have a violently stimulating effect on the temper. This is how one of the tutelary medical deities of the Springs "goes for" the President of the Arkansas State Medical Society, who had accidentally omitted his name from a list of local practitioners: "This specimen of physical and moral turpitude, this professional hybrid, with the soul of a snake, the heart of a jackal, the brains and propensities of an ass—this upstart President of the State Society—the worst charlatan in Hot Springs, in point of impudence and mendacity—for originality of method and black arts in misleading the public, would prove a Derby winner in the chamber of horrors of hell, etc." Hot Springs certainly deserves its name if it inspires much eloquence of this ebullient kind.

#### PAIN ON RUPTURE OF GRAAFIAN VESICLE.

Dr. Eliza E. Grossman writes as follows upon this obscure subject, in the *Pittsburg Med. Review*, for June:

We do not find the inferior hypogas-

tric nerve classified as belonging to the nerves of sensation. We find that almost if not all of the pelvic viscera are supplied by this plexus of nerves. I believe we might classify this plexus as having distinct sensory fibres. In going back now to the rupture of the vesicles and descent of the ovum, we find a rupture of three distinct coats as having taken place, viz., internal vascular and external fibrillated coat and the tunica propria. At the time of rupture—I may say the very instant that rupture takes place, there is a quick, sharp lancinating pain, lasting but an instant and in the region of the ovary. This may occur anywhere between two and five days before the menstrual flow manifests itself. I think by this that ovulation is usually at the left side, although sensation of the ovarian rupture is frequently experienced as being in the right side. Should this be physiological the advantage of this sign, “lancinating pain,” would certainly not be very great, but it would add something to our knowledge of physiology. Also in case we have a patient with a sanguineous discharge from the uterus, it would be circumstantial evidence of menstruation instead of pregnancy with an impending abortion. It might also enable us to determine whether both ovaries were functioning or whether it depended wholly upon one. If each ovary performed its function alternately in a healthy woman the knowledge of this sign might enable us to explain in some cases irregular menstruation.

#### GOUTY TEETH.

In the *Omaha Clinic*, June, Dr. Hipple writes as follows:

Dr. Thompson, of Topeka, Kansas,

and others have given us a description of the so-called gouty teeth. These are yellow, short and thick, and although, as in syphilis, the teeth do not always exhibit the same characteristics, it is safe to suspect a gouty diathesis whenever the teeth are abnormally developed in the manner described. It has been noticed, too, that erosion of the teeth, in which there is a gradual wasting away of the enamel quite different from the ravages of decay, is associated frequently, if not usually, with this condition, and cases are on record where patients have been able to foretell an acute attack of the gout by the peculiar sensitiveness of their teeth.

The cause of dental erosion, until very recently, was a mystery, but many now believe that the destruction of the enamel is due to the direct action of an acid secreted by the labial and buccal glands. Since it seems to be established that the various secretions of the body are decidedly acid in the gouty subject the connection between the gouty diathesis and the transverse grooves occasionally found on the labial surface of the teeth, can readily be understood.

#### A COURT-ROOM EXPERIMENT.

The *Omaha Clinic* reports the following item from a recent trial in the West:

For tricks that are peculiar the “Chinee” is not alone in this as a vocation. The lawyer (sic) it would seem is too often also of the same feather, judging from the following, reported by Dr. Clark in this issue, on the Morse case of poisoning at Beatrice, Neb.

“In the argument of the case Col. Colby precipitated a scheme that has given him a lot of fame, which although cheap, and bought by a pettifogging trick, seems real. . . .



“Col. Colby, himself a chemist, was apprised of the fact that chloroform was used to extract strychnine from aqueous solutions, and that it being denser than the water, would carry down to the bottom of a glass vessel all the strychnine it contained. So he procured a tall narrow wine glass and poured into it a very small portion of the alleged poison and filled the glass up with water and allowed it to subside—the chloroform completely carrying to the bottom all the poison.”

“When he had wound up to one of his studied periods in his speech, he would raise the graduate to drink out of it and at the same time looking over to me would exclaim, ‘Doc, see my diaphragm flop,’ to the infinite delight of all in the large court-room, who, of course, enjoyed my awkward position. My mouth was closed as I was a witness for the State, but I saw the trick all the time.” Curiously a juryman discovered the trick and noted that the lawyer only drank the supernatant water.

#### TREATMENT OF INTRA-CAPSULAR FRACTURE OF FEMUR.

Discussing recently in one of the medical societies a paper upon this subject, Dr. William S. Stewart remarked: I wish to give a little experience that I had ten or fifteen years ago. I was called to see an old lady who had tripped on the carpet, and fell on her hip. I readily discovered a fracture at the neck of the thigh-bone, within the capsule. At the request of the family, a surgeon saw the case with me, and confirmed the diagnosis. The limb was then dressed according to his recommendation by the method then in vogue—extension and counter-extension, some fifteen pounds weight being applied. She suffered the torture produced by this

for twenty-four hours. The next day I reduced the weight to five pounds. The family then became dissatisfied, and I said that I would turn the case over to a surgeon, if they would first call in Dr. Agnew to see that nothing improper had been done. After Dr. Agnew had examined the patient, and expressed his opinion to the family (stating that there would be no bony union), they begged my pardon, and requested me to continue in charge of the case, which finally, at their earnest solicitations, I agreed, provided I be permitted to do what I thought best. I then took off all the weights. The result was that in six or eight weeks the patient was out of bed, with good use of the limb, was able to go about, and go to market and carry a heavy basket, until a year or two since, when she died from some other cause.

Having had this experience, it opened my eyes to the treatment of such fractures. I do not hesitate to treat all my cases, young or old, in that way, by adjusting the limb between sand-bags, and keeping the patient quiet. I have several cases to which I can refer, who are now in perfect health, are able to run or walk, and have good use of their limbs, and were not tortured to death by the old method.

#### THE INSOMNIA OF CHOREA.

From an excellent address, with illustrative reports of cases, by Dr. Barrs (*Lancet*, May 20th), we clip the following: It is not easy to say precisely what element in any given case seriously threatens life and calls for unusual treatment, but the simultaneous or separate presence of—(1) great violence of the movements (2) rapid wasting, (3) bedsores, (4) insomnia, (5) a high tem-

perature, and (6) the rheumatic state, would, I feel certain, indicate a degree of severity of the disorder which may readily threaten life and call for immediate and vigorous treatment. My experience of these violent cases of chorea leads me to attach most importance to rapid wasting, the formation of bedsores and total insomnia. They are all three dependent upon the violence of the movements, and two of them, I feel strongly, are a certain means of killing the patient—namely, wasting and sleeplessness. As to the wasting, I would only observe this that there is an exceedingly rapid and striking wasting or shrinking of the body in certain very violent cases of chorea, which, although dependent upon the disease, is frequently quite unaccounted for by the vigor of the movements or the inability to take food. It can, of course, only be met by abating the movements and feeding. The insomnia I am strongly inclined to regard as *the* index for purposes of treatment; and I am quite convinced that it is a most dangerous thing to allow choreic patients to continue for long periods without sleep, and especially so if there is delirium. We know that sleep is the natural means of arrest of the choreic movements, and in inducing sleep we are arresting that which tends by its severity to put the patient in danger.

The cases I wish briefly to narrate are all of them examples of severe chorea treated on this principle. We are now possessed of several efficient and safe hypnotics—viz., chloral hydrate, chloralamide, sulphonaland perhaps paraldehyde.

Of these, chloral hydrate is perhaps the most reliable, for there is no doubt that, given in sufficient quantity, it may

be relied upon (like opium) to produce sleep; but it has some disadvantages. It is unpleasant to take and in administering it in large doses by the mouth to the patients suffering from chorea this is not an unimportant point. It also occasionally produces vomiting and diarrhœa and, perhaps most important of all, it is a powerful cardiac depressant. In spite of all these drawbacks I am inclined to prefer it to chloralamide, which, though free from the disadvantages of chloral hydrate, is somewhat difficult to manage, and, it may be, even dangerous, from its comparative insolubility causing delay in its action. Chloralamide is an excellent hypnotic if we could be quite sure of its immediate absorption. The systematic administration of chloral hydrate in the treatment of cases of severe chorea is of course no new thing, but the recorded cases in which it has been used are so few in number that it may not be useless to relate to you five cases which have come under my care during the last few months; but before doing so I wish briefly to draw your attention to some of the observations already recorded. Professor Gairdner in 1870 recorded a case of chorea occurring in a child eight years of age, in which repeated moderate doses of chloral hydrate were given. On a certain day, and entirely by misadventure, a dose of sixty grains was given. Symptoms of poisoning very soon followed, but at the end of twenty-four hours the patient awoke permanently relieved of the choreic movements, which had persisted in spite of treatment for seven weeks. In some of the cases I shall relate this sudden and complete arrest of the choreic movements by large doses of chloral was very well seen. In 1870 Dr.



Carruthers recorded the case of a girl, eighteen years of age, who had suffered from chorea for two years, in which he gave a dose of thirty grains of chloral hydrate to produce sleep, this being repeated daily for fourteen days with the most successful results. In the same year Dr. Russell, of Birmingham, recorded a case of chorea gravidarum of five months' duration, which developed in its later stages an extreme degree of violence and was successfully treated by repeated doses of chloral hydrate sufficient to induce sleep. In 1877 Dr. Bridges recorded two successful cases and refers to the very unsatisfactory effects upon patients of small doses, which are not sufficient to produce sleep; indeed, he seems to have thought—and I am inclined to agree with him—that chloral hydrate in small doses is not only useless but absolutely dangerous in cases of violent chorea. Until 1889 the use of chloral hydrate in severe or protracted cases of chorea had not attracted much attention, but in that year Dr. Bastian published an important contribution on the subject, in which he recorded a case, admittedly somewhat anomalous in its features, by the induction of continuous sleep by means of chloral. He says that in the twelve years previously to 1889 he had treated eight or nine cases in this manner, and he goes on to define the class of cases for which such treatment may be advisable in the following words: "In all ordinary cases of chorea I never think of having recourse to it. With rest and very various kinds of treatment in the course of six to twelve weeks such cases recover. Then again, in the most acute and severe cases of chorea, in which the temperature is raised and the movements are violent

and continuous, with or without delirium or maniacal symptoms, I have never yet tried this mode of treatment, nor should I recommend its adoption. It is, I think, especially applicable to a class of cases in which there is no fever and no heart disease, but where the movements are usually severe and continuous."

I wish to draw your attention especially to the limitations within which the treatment should be adopted, as laid down by Dr. Bastian, because I think you will see that most of these were overstepped in the cases which form the subject of my remarks. In three of them there was considerable pyrexia, in two acute rheumatism (one fatal), and in almost all delirium of greater rather than less severity. His lecture was followed by a further communication from Professor Gairdner, in which he sums up his experience of chloral hydrate as follows: "(1) It sometimes succeeds in chorea absolutely where other remedies fail; (2) it can be depended upon, as a rule, in very severe cases to initiate a treatment which may be afterwards successfully carried out otherwise; (3) in such cases it has an almost absolute power of suspending or controlling spasm during the persistence of its deep hypnotic action and is therefore invaluable as a palliative (care being taken of course to avoid poisoning, acute or chronic); (4) this or other limitations will interfere with the curative action of the remedy in some inveterate cases; the failure of chloral hydrate in these cases being common to it and all other remedies."

#### NATURE AND TREATMENT OF CHLOROSIS,

After stating at length his reasons for believing that the source of this disease-



change is the intestinal canal, Dr. Forchheimer writes (*Amer. Jour. Med. Sci.*, July, p. 893):

Lastly, I wish to present briefly the therapeutic evidences I have gathered. Sir Andrew Clark states in his paper that "If in the treatment of this malady I were perforce limited to the employment of one sort of drug, the drug which I should choose for use would be an aperient." In the eleven cases from which I shall draw my conclusions I have used neither iron nor aperients, but have given salol or hydro-naphthol (so-called). It will be readily understood why the number of cases is so small when the statement is made that chlorosis of high grade is not very common with us, and that all the cases which I have seen have not been exclusively treated by these drugs. The object of the method was to introduce some substance into the small intestine, so as to prevent abnormal decomposition, and none better suggested themselves than salol, with its salicylic acid, at first, and latterly hydro-naphthol. In order to make the therapeutic tests as pure as possible, no laxatives were administered, but the bowels were emptied by means of agents acting upon the large intestine only (enemata, flushing the large intestine, or glycerin, either as an injection or suppository). The eleven cases were all females, varying in age from fifteen to thirty-five years; menstrual difficulties were present in seven cases—the most pronounced case claiming to be regular in every respect; constipation was present in six cases, stomach trouble in four. In all the cases the urine presented the chemical characteristics mentioned before. Two of the cases were

chronic chlorosis, one of which was cured after a long siege, the other one presenting relapses, so that she cannot be reported as cured. The quantity of hæmoglobin varied at the beginning from 40 to 70 per cent., and the number of red corpuscles from 3,766,000 to about the normal for women. Six of the cases were treated with salol, five with hydro-naphthol, and one with both. The patients were kept under treatment until hæmoglobin reached 90 per cent. or over, and the time of treatment varied from five weeks, as the shortest, to three years in one case. All precautions were taken to establish accuracy in blood examination (counting a sufficient number of squares in the hæmocytometer, the arrangement of the light for the hæmometer, examination at the same time of day, and with reference to meals, etc.). The results, expressed in general terms, were steady increase in hæmoglobin, interrupted by regular diminution as the result of menstruation and several other causes. When a gain was made, the smallest amount gained in one week was five per cent., the greatest twenty per cent. In one patient, the only exception, it took two weeks before the remedy (salol) produced any effect, but in two weeks after that the hæmoglobin had risen from 65 per cent. to 85 per cent. With the rise in hæmoglobin all the patients began to improve; the nearer 80 per cent. the more the symptoms began to disappear, and, from ordinary examination, without blood test, most of the patients would have been willing at this point to have been discharged as cured. In the obstinate chronic case referred to above, the hæmoglobin was just as surely increased as in

the others, but as soon as treatment was stopped the hæmoglobin would again sink, so that, after the end of two or three months, the patient would present herself again with hæmoglobin 55 or 60 per cent. In no way, however, could she be looked upon as disproving the effects of these two remedies upon hæmoglobin - formation. Hydro - naphthol seemed, upon the whole, more efficacious than salol, the results being more quickly obtained and the rise being more rapid. If any deduction could be drawn from the different action of the drugs, it would be that salol acts both upon lower forms of life and upon enzymes, while hydro-naphthol probably acts only upon the former. However this may be, both act by causing increase of hæmoglobin, the salol acting, in addition, especially in the direction of producing a decided increase in the number of red corpuscles.

In conclusion it may be stated that, possibly, some other origin for hæmoglobin may exist than in the intestine; from all evidences, however, this is the principal source and in chlorosis the most important.

### Recommendations of Therapeutic Agents.

#### PROPHYLAXIS OF CHOLERA ASIATICA.

"I have been prescribing preventive medicine for diphtheria for many years and have never had a second case develop. When diphtheria appears I have made it a constant practice to put all those exposed to infection upon Listerine, taken in drachm doses at each meal; and during the three years of la grippe I ordered my family and all my friends' families to use it after each meal, as long as there were

any cases in our city. I did not once fail in preventing both diphtheria and la grippe when Listerine was taken faithfully. In several instances persons being called from home neglected the Listerine preventive treatment and returned in a week or two with la grippe fully developed. I believe that the only safe quarantine against cholera is to quarantine the alimentary tract, and for this purpose I shall trust to Listerine. It will prevent diphtheria and la grippe, and I feel sure it will prove equally efficient in the preventive treatment of cholera."

—J. H. Stringfellow, M. D., Prof. Hygiene, Northwestern Medical College, St. Joseph, Mo.

Iodide of Strontium.—While the salicylates answer all purposes in acute rheumatic fever, they are of little value in the non-febrile forms. Two such cases have been under my care during the past winter. As long as they took sodium salicylates in full doses, the symptoms were reduced to a minimum, but immediately returned on the discontinuance of the drug, which, moreover, had a deleterious effect on the health. I then directed these patients to take the solution of Strontium Iodide (Paraf-Javal), beginning with four drachms daily. Improvement followed, and the dose was gradually reduced to one-half. The effect was very good; the symptoms gradually subsiding while the general health improved. Both patients resided in damp houses; and the rheumatism showed a tendency to recurrence, though at intervals much longer than when under the salicylates.—Waugh, *Times and Register*.

In cholera times quarantine the stomach.

### Medical Items.

Dr. Henry O. Marcy has removed to 180 Commonwealth Ave. (near the Vendome), Boston.

We learn with pleasure that Dr. P. T. Vaughan, a graduate of the Baltimore Medical College, class of '93, received the highest marks in the recent examination before the Alabama State Board of Medical Examiners, and that he was immediately appointed Assistant Resident Physician to the Alabama Hospital for the Insane at Tuscaloosa, Alabama.

We observe with pleasure that the article of Dr. C. L. G. Anderson, of Hagerstown, on "peach fever," published recently in our JOURNAL, has been thought worthy of an extensive reference in the *British Medical Journal*, although the editor does not make mention of the JOURNAL through which the article was brought to his attention.

Lister says that the surgeon's enemies are almost always sporeless bacilli, and though some of these show great resistance to the action of antiseptics, such as the staphylococcus pyogenes aureus, the common cause of suppuration, it has nevertheless been shown that carbolic acid destroys these organisms more rapidly than corrosive sublimate.—*Cincinnati Lancet-Clinic*.

One of the most interesting studies for physicians at the World's Fair will be the sewerage system. Six thousand sanitary closets will be built in marble compartments. From these the sewage will be conveyed to large tanks at the southeast corner of the grounds, there

purified by chemicals, its solids pressed into cakes and burned in furnaces. Arrangements are made for a permanent city of 300,000 inhabitants. This method will therefore receive a thorough test.—*Ex.*

The Children's Fresh Air Society has begun its good work by sending poor city children to country homes in the neighborhood of Olney and Brighton, Montgomery County, Md. From this time until the close of the season children will be sent out by the society into the country from time to time. More good country homes are needed for the many little ones anxious to go. Communications are to be addressed to the Children's Fresh Air Society, at 317 and 318 Law Building, St. Paul and Lexington Streets, Baltimore; all contributions are to be sent to the treasurer, F. R. Owens, at the rooms.

The Supreme Court of Illinois gives a definition of a medical expert which is so matter-of-fact that we take pleasure in reproducing it for the benefit of our readers. The Court says: "A practising physician who is shown to be a graduate of a regular college and to have practised his profession for many years, is competent to give his opinion upon a hypothetical question, setting forth the symptoms of a deceased person, whether the death was from the effects of arsenical poisoning, although he may not be shown to have had any case of such poisoning. A medical witness, in giving his opinion as an expert, is not confined to opinions derived from his own observation and experience, but may give an opinion based upon information derived from medical books."—*Brooklyn Med. Jour.*



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## Original Articles.

### ADDRESS

DELIVERED BEFORE THE ALUMNI  
ASSOCIATION OF THE SCHOOL OF  
MEDICINE IN THE UNIVERSITY  
OF MARYLAND,  
APRIL 18TH, 1893.

BY SAMUEL C. CHEW, A. M., M. D.,  
Professor of the Principles and Practice  
of Medicine in the University  
of Maryland.

(Published by request of the Alumni Association.)

My Fellow Alumni: We are once more gathered together in this ancient hall on one of those festal occasions upon which our venerable Alma Mater renews her youth as she takes into her adoption the successive bands of her foster-children; and we, her family, old and young, are here to do her homage and to congrat-

ulate her upon the fact that as her years increase, so also does her strength.

Old traditions and time-honored associations are not the most valuable things that may environ an institution of learning and endow it with power for good, yet they have their value.

The energy and grasp of youth, if productive of good work, are far better than the weakness of age; and results, which in themselves are excellent, are not to be discredited or lightly thought of because accomplished by the young. But herein is found a contrast between individuals and institutions. The former, in the lapse of time and in the conditions of humanity, must sooner or later fail; whereas the latter, though growing in years, may never grow infirm; weaknesses may never affect them; and though surrounded by "that which should accompany old age, As honor, love and troops of friends,"

they may still flourish as in immortal youth. And so, viewing the matter in part from the side of feeling, if we, the Alumni of the School of Medicine in the University of Maryland, find her striving to make the best use of such means as she has; striving to increase her resources and facilities for teaching; strengthening whatever weak points she may have; taking the initiative, as time and again she has done, in establishing new departments of instruction; and ever raising higher and higher her standard of requirements; then we may find some satisfaction in the thought that we are not altogether *novi homines*, but that we are bound with our Alma Mater to the traditions of an honorable past.

On the banks of the Thames may be seen the "spires and antique towers" of a seat of learning, where for four hundred and fifty years, from a time reaching far down the centuries onward to our own day, many of the greatest intellects of England have been trained: a Chatham for a work in Parliament which should cause his name to be cherished in the heart of every American; a Wellington to win a fight, which, as he himself said, was begun on the field of Eton; a Gladstone for a life of persistent labor and achievement—the greatest of all being perhaps yet to come—which is almost without parallel in the annals of the human intellect. Yet, do you not think that over and above the sense of intellectual power which is, as it were, in the very air they breathe, the men of Eton of to-day are elevated and stimulated by the thought that theirs is the home,

"Where grateful science still adores  
Her Henry's holy shade."

In a new country like ours such an-

tiquity cannot exist. But all things are relative; and neither can Eton claim such age as the University of Bologna, which was a seat of learning in the reign of Charlemagne and enjoyed a great celebrity early in the twelfth century. Here, as physicians should remember, Malpighi, marking an epoch in medicine, was the first to apply the microscope to the study of anatomy, and connected his name forever with the structure of the kidneys and the spleen; and here from every part of Europe, and from Asia too, classes were gathered when Eton was a marsh by the river.

All things are relative; and so from the standpoint of western ideas we may well be satisfied with an origin which is nearly co-eval with the establishment of independent government in this country by the adoption of the Constitution, after which not two decades had passed before the University of Maryland had entered upon her career, which has been continuous and uninterrupted ever since. Of the great multitude who during these many years have received her diploma as the authentication of their enrollment in the medical profession, a large proportion have of course passed over to the majority, as the tender and sensitive classic phrase has it; *abierunt ad plures*. But her living alumni are to be numbered by thousands. And as the institution which has sent them forth, embodied in her authorities, watches their careers and earnestly hopes that they may reflect credit upon her, "adorning the Sparta" which has brought them forth; so in their turn they may rightfully demand that she should be a leader in the movement, now so general, for better preliminary education in those who are seeking ad-

mission into the medical profession; they may rightfully demand of her the most thorough and accurate training in every study that bears upon medicine; and that she should require the very highest standard of attainment as an essential pre-requisite for obtaining the medical doctorate. This demand her alumni and the community in general have a right to make of the University of Maryland, and to regard compliance with it as a condition of their continued confidence in her. This demand she is not only prepared to accede to, but she has already in large measure anticipated it.

If a graduate of our University of twenty years ago could devote one week to the curriculum of work done by students of the present day, he could not but be impressed by the difference between the opportunities now offered and those given him in his undergraduate days. And what was true of the University of Maryland was true of other medical schools in this country at that time; of those that were the largest, as regards the number of pupils attending them, and that were reputed the best. Here as elsewhere, in schools, I say again, reputed the best, students were graduated and sent forth as "*scientiarum ac medendi artis abunde periti*"—oh, the bitter irony of the words *abunde periti*—who, as regards their chemistry, had never handled a test-tube or a retort; as regards their physiology, had never seen the action of the gastric juice, the pulsation of the heart, the circulation of the blood or the response of any nerve to a stimulus; as regards surgery, had never introduced a catheter or lanced an abscess; as regards obstetrics, had never witnessed the process of parturition; as regards medicine

proper, had never heard a crepitant or any other sort of a rale, nor listened to a cardiac murmur. But happily all this has been changed. Attendance upon the courses of instruction for three years has been made obligatory; laboratory work in chemistry and in histology is required of all our students; bedside instruction in surgery, medicine and obstetrics, clinical teaching, that is, in the literal and true sense, is imparted to all; and, as an essential part of these improvements, and in order to render them really effective, the system of graded courses has been adopted. Now that this plan is in full and effective operation and its value seen by its results, it seems hardly credible that the former system could have been maintained so long; the plan, I mean, of giving the same instruction to all, however various and unequal their degrees of preparation might be, the absurdity of which seems so obvious that to state the case is to prove its folly. That condition of things, I will say, speaking in behalf of the University of Maryland, will never be returned to; with her there shall be *nulla vestigia retrorsum*. She has embarked upon her present course because it is a right course to take; and let the issue be what it may, she will abide all stress and storm. Whatever detriment may appear for a time to be wrought to her interests, as measured by the size of her classes, that result she will be entirely prepared to accept, and will count her loss, if such it be, a gain.

She will welcome such students as seek her instruction, however small their number may be, with the thought that she has, in Milton's phrase, "fit audience, though few;" and she will send them



forth bearing her diplomas, as their credentials to the world, with the conviction that she has faithfully discharged her duty to them.

These things, my fellow alumni, the school of your graduation has done, and further things she pledges herself to do, as demanded by the *Zeitgeist*, the spirit of modern science, which is always, however it may be sometimes overclouded, the spirit of truth. Will you renew your allegiance to her, and aid her effort to maintain what is just and true and right? Then, as her past has been honorable, so will her future be likewise honorable, and prosperous according to the measure of true prosperity. For her past she can point to the esteem in which she has ever been held, and to the careers of many of her alumni, who have filled posts of honor and responsibility in all the branches of the public medical service, or who have been called to be teachers in many institutions of medicine throughout the country; in the University of Virginia in the south, in Harvard and the University of Pennsylvania in the north, and in the west as far as to the Golden Gate of the Pacific. Whatever these have since become or whatever they have made themselves, here was the nursing bosom at which they drew their first draughts of professional knowledge. For her future your University will seek, as she is seeking now, to give those pupils who may be entrusted to her better and better preparation for duty in the calling in which they shall be engaged.

And what is that calling? Truly it is a conflict, and a momentous one, for which the very best endowments and the very highest attainments are no undue equipment.

The scenes of that conflict may appear to be only the wards and amphitheatres of hospitals, or the hushed air of chambers of sickness; but if the veil were withdrawn, these might be seen as portions and parcels of that vast arena upon which is waged with unceasing warfare the tremendous contest between good and evil.

On the wall of the corridor leading to the anatomical theatre above this hall a student of the University of Maryland drew, more than fifty years ago, with rough delineation, it is true, but with some real appreciation of the spirit and power of the original, the picture of the fight between the great Archangel and his foe. It was perhaps with a true instinct, and in recognition of the facts that anatomy is at the foundation of all the medical sciences, and that the final purpose of these sciences is that they be used in behalf of good against evil, that our fellow alumnus of long ago placed the picture where it is.

Some of you, no doubt, have gazed, as I have many times, and every time with renewed wonder and admiration, at the magnificent original of this picture painted nearly four hundred years ago, and now hanging on the wall of the gallery of the Louvre, one of the greatest and latest works of the divine Raphael.

As you look at the Archangel's face, no trace of passion and no sign of exultation or triumph are depicted on that victorious brow; but only a marmored calmness, as with uplifted arm and with supreme confidence in his own power and his own righteousness he plunges his purifying and destroying spear down through his adversary's heart.

Such a face, you feel, may fitly have belonged to the leader of those embattled

hosts, when the very dome of heaven "rang to the roar of an angel onset."

For many years this picture has been associated in our minds with our own University, and we may rightfully regard it as a symbol and type of our professional work.

Sometimes an unexpected light is thrown by modern investigations and discoveries, not only in archæology, but in the physical sciences and perhaps the psychical sciences too, on passages written of old time and in old books, which may previously have seemed more or less vague and unintelligible.

Some able and prominent members of the medical profession in France have of late years been specially engaged in the study of certain phenomena which are grouped under the term Hypnotism.

Allowing for some exaggeration in the reports made upon this subject, it may be believed that there is a residuum of truth in them, and that under certain circumstances a person in the hypnotic state, when the mental faculties are dulled by sleep or by a condition akin to sleep, may be so influenced by the will-power of another as to be led to perform acts which under a different condition he would not do. The influence is by no means insuperable; it may be resisted and overcome. Some persons, it would seem from the accounts given, having less resisting power, less strength of opposing will, than others, are more readily brought into this state, and yield more immediately and completely to the domination. The influence exercised by the experiment, or rather the mode in which this influence acts, is termed "suggestion." Perhaps as regards its relation to the mental and moral state of the person acted upon, it is of the nature of what

in old books is called "temptation," about which we all know something from personal experience, and which also may be yielded to or may be resisted. Possibly—and remember that we are now engaged only in speculation—such suggestion or temptation may come from agencies other than human, which even on the principles of agnosticism may be conceived to exist. The consequences of suggestion may be illustrated by the different conduct of the two soldiers in that drama which is regarded by an eminent artist, Mr. Hallam, as the greatest work of the greatest name in all literature. The same suggestion is presented to the minds of each of them. That of Macbeth is open to any promptings, however evil they may be; it is ready, as he says,

"to yield to that suggestion,  
Whose horrid image doth unfix  
my hair.

And make my seated heart knock  
at my ribs."

He trifles with it and affects to put it by:

"If chance will have me king, why,  
chance may crown me;"

but the chance for which he waited, of which he was willing to avail himself, and which came when

"Good things of day began to droop  
and drowse,"

was the opportunity of murder. The suggestion imparted was the temptation to which he yielded.

The same insidious approach is made to his fellow-soldier Banquo, but his purer heart strives against it and the temptation is overcome.

"Merciful powers! he exclaims,  
Restrain in me the cursed thoughts  
that nature  
Gives way to in repose."

"In repose;" when the mind is slumbrous and its faculties are less alert, then, according to the doctrine of modern hypnotism, it is most open to suggestion, which in Banquo's case is strenuously resisted and the tempter fails. The hypnotic suggestion of modern psychology may be a new and scientific term for old temptation.

Let me show you by another instance how light may possibly be thrown upon old teachings by modern discoveries.

Dr. Tyndal tells us as the result of some of his later investigations that the diffused light in the atmosphere is due to reflections from countless millions of suspended particles of matter, and that but for these the very air itself, if deprived of such accessories, would be involved in the deepest obscurity; would be, indeed, a region of utter darkness.

And elsewhere we read of a "power of darkness" which from its sphere of operation is also called the "power of the air." May then the borderland of that realm of darkness, the outskirts of that "unseen universe," be the region into which our microscopes partly penetrate?—a region crowded, it may be, with malignant forms of animated existence,

"Haunting the interspace of world and world,"

ministers of an evil power, of which we know little except that they are potent for harm; such agencies as the guilty king in the great tragedy already spoken of, called the "common enemy of mankind."

Modern medicine, it has been claimed, made a great advance when it found that diseases are only perverted physiology and not substantial entities of diverse kinds, *daimones* or demons, as they were

superstitiously held to be by an early school of medicine, seeking to gain admission into the body, and working havoc when they entered it. That was a folly of the dark and unscientific ages, we say in our wisdom, and in reality disease is only perverted physiology. Ah! but what if after all there should be some measure of truth in this old and superstitious pathology? For the question presents itself, What has perverted the physiology? What but those very demons of typhoid fever and tuberculosis and cholera and diphtheria which we know, and others of the devilish brood as yet imperfectly known or wholly unknown; agencies which in modern fashion—it is perhaps only a question of terms—we call bacilli, and which poison the tissues and organs and "touch corruptibly the life of all the blood."

And so may it be that as physicians we "wrestle not against flesh and blood, but against principalities and powers;" and that we may rightly find an inspiration and an incentive to more earnest work in the thought that at however infinite a distance, and with however infinite inferiority of intent and capability, we are yet engaged in the same contest with One whose mission it was to "destroy the power of death."

These things are mere figments of the imagination, you may say—*kinder-märchen*—tales for children, to be put away with other childish things.

Be it so, if so you prefer to have it; but even if figments, yet none the less they may stand as symbols and tokens of that mighty contest between good and evil, whether physical, or spiritual and moral, which will go on until the consummation of all things.



In this contest we are all engaged in virtue of our calling; into it you, the youngest of our fellow alumni, who have just entered the ranks of the medical profession, have been sworn as soldiers this day. For your guidance in the conflict before, you take this as a final farewell word from one of your teachers, who may at least claim that he has striven to help you: "Quit you like men—be strong."

AN OVARIAN TUMOR WEIGHING  
111 LBS. REMOVED FROM A  
CHILD OF 15, WHOSE  
WEIGHT WAS 68 LBS.\*

BY W. W. KEEN, M. D.,  
Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College.

Miss B., of Benazette, Pa., was first seen by me at Driftwood, Pa., February 26, 1892, at the request of Dr. V. K. Corbett, of Caledonia. She was then fourteen years of age and had never menstruated. About eighteen months before I saw her, her abdomen began to enlarge. Six months afterward Dr. Corbett was consulted for an attack of considerable pain in the left side of the abdomen. He found that she was only voiding eight ounces of urine in the twenty-four hours, but under proper treatment this soon reached a quart in amount, and has remained so ever since. He never discovered any albumin in the urine. In October, 1891, she had been tapped by a gynecologist, who is said to have diagnosticated a solid and probably malignant tumor, connected most likely with the liver, omentum, and ovary, and who deemed its removal not feasible.

I found the abdomen enormously distended with fluid and advised very

strongly that a small incision should be made in the abdominal wall, so that I could determine the relations of the growth with accuracy. Her father, however, was not present, and had made it a condition that nothing beyond tapping should be done. I tapped her immediately and removed considerably over three gallons of amber-colored fluid. When this was evacuated I discovered a lobulated tumor on the right side of the abdomen, under the liver and apparently attached to it. It was evidently cystic in part, there being at least two cysts perceptible. Each of these I tapped, obtaining from the upper one a light fluid and from the lower one a much darker fluid. On account of her age no vaginal examination was made. The fluids pointed strongly toward an ovarian cystoma. I again advised an exploratory incision.

April 29, 1893. The patient was finally brought to the Jefferson College Hospital. She has been tapped twice since February, 1892, the last time in February, 1893, when six and a half gallons were drawn off. She is now enormously swollen. The measurements are as follows: From the ensiform to the umbilicus,  $16\frac{1}{2}$  inches; from the ensiform to the pubes,  $29\frac{1}{2}$  inches (this measurement in myself reaches from the ensiform to the middle of the calf of my leg); circumference, 49 inches. The veins over the abdomen are very large. Nothing can be made out in the interior in consequence of the enormous abdominal distention. Examination of the urine shows no albumin and a very slight trace of sugar (?).

*Operation.* April 30, 1893. A small incision was made in the median line

\*Read before the Philadelphia Academy of Surgery.

above the umbilicus, as the greater mass of the tumor lay there. A large trocar was thrust in and evacuated a very large quantity of characteristic opalescent ovarian fluid. The escape of this fluid revealed through the abdominal wall large masses lying especially under the liver and in the right iliac fossa. After this evacuation I enlarged the incision until it measured eventually about eight inches in length. I introduced my hand and found an enormous ovarian cyst, reaching up to the diaphragm and pushing everything out of its way. There were a number of moderate adhesions, chiefly to the belly wall and the omentum. The viscera were fortunately entirely free. The pedicle was only  $2\frac{1}{2}$  inches broad. The tumor arose in the right ovary, the left ovary being healthy but small.

The weight of the solid mass removed was twenty-seven pounds, and by actual weighing the fluid removed weighed eighty-four pounds, making a total of 111 pounds. The child herself weighed but sixty eight pounds.

After the removal of the tumor I never saw so curious a looking abdominal cavity. It looked almost like that of an eviscerated cadaver in the dissecting-room. The tumor had so pushed the liver to the right and backward, and the stomach to the left, that nearly the whole of the diaphragm was exposed, and flapped up and down with the pulsations of the heart. Down the middle of the cavity the bodies of the vertebra were entirely exposed, showing the aorta and vena cava to their bifurcations, the intestines being a very minor consideration and pushed to each side in the hollow of the ribs and the lumbar region. When the abdominal wall was sutured the abdomen was exces-

sively scaphoid, the anterior abdominal wall lying directly on the aorta and vertebrae. The puckering of the skin, although moderately marked, was much less than I had expected.

When the operation was completed a glass drainage tube was inserted and she was put to bed in very fair condition, in view of the gravity of the operation. The tumor was a multilocular cyst.

May 18, 1893. The child has made an uninterrupted recovery. The drainage-tube was removed on the fifth day, when the discharge had become almost nothing, but three days later a slight rise of temperature took place, and the discharge recommenced. A small rubber drainage-tube was therefore reinserted for a few days. She sat up at the end of two weeks, and will go home as soon as the slight discharge from the drainage opening ceases.

*Remarks.* I have not had time to search through the literature of ovariectomy, but so far as my memory serves I have never known a larger tumor removed from a child. It weighed just one and a half times as much as the patient. Her recovery has been most satisfactory in spite of a very poor and capricious appetite. The chief lesson the case teaches is the value of an exploratory incision in every case of doubt. Had this been done, instead of a mere tapping, in October, 1891, when the tumor was much smaller, the prognosis would have been much more favorable, and she would have been spared a year and a half of needless suffering. What seemed to be a most formidable operation really proved to be almost a simple one, the adhesions and the pedicle being most favorable for the speedy recovery which has ensued,



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BALTIMORE, JULY 15, 1893.

**Editorial.****THE THERAPEUTICS OF MENTAL DIVERSION.**

The effect of unvaried repetition of an impression upon a perceptive nerve organ is a deadening of the sensitiveness of the said organ to that particular impression. Variety is not merely the "spice of life;" it is rather an essential ingredient in the pabulum of normal existence for all sentient organisms. The alternation of day and night, of summer and winter, of waking and sleeping, of satiety and hunger, are all evidences of accommodation to this great law.

In the action of the mind itself there is an evident periodicity—an ebb and flow of thought-power. The maintenance of continuous high pressure of intellection for lengthy periods, which would certainly wreck the brain, is under normal conditions rendered impossible by the onset of mind-fatigue—of uncontrollable mind-inactivity—after the

high tension has been kept up for a period of time the length of which depends on the bodily vigor and the thought-discipline of the individual.

Under the extreme pressure of business competition, it is no rare occurrence nowadays for individuals to compel their minds to work on long after the normal limit of healthful activity has been reached. The fear of business failure, the love of gain, over-enthusiasm for the work itself, serve as goads, continually inciting the weary mind to self-destroying excess of activity. And so intense may these motives become that the individual may not be conscious of the over-draught upon his intellectual power, until the mind, if we may use the expression, collapses.

Occasionally, the stimulus of alcohol or of other drugs is employed, in order that the unnatural mental pace may be maintained.

To prevent the damage to brain substance which must follow too continuous tension of thought, the habit should be formed early in life of taking periodical relaxation, without waiting for the, perhaps indistinct, warning of "Nature's alarm-bells"—pain, discomfort and insomnia.

The wisdom of the observance of a seventh day rest is shown by its displacement of occasional State holidays in alien nations which have come into contact with European civilization. And on physiological grounds merely, if on no other, the weekly Sabbath for the mind and body will doubtless from age to age strengthen its hold upon the human race.

Apart from the weekly rest, which is most beneficial when the mind is turned



away from ordinary avocations to an entirely new set of thoughts, periodical diversion should be sought. What form of recreation should be pursued must be determined by the peculiar needs of each individual; the general rule being that, within reasonable limits, that recreation is most restful which gives the greatest enjoyment. One man will find delight in hunting or fishing, another in scientific excursions for the study of natural phenomena, a third in social intercourse. One mind will obtain rest through change of thought-concentration, another needs complete relief from intellectual exertion.

An important advantage derived from a liberal education lies in the broadening of the mental sympathies, so that interest is taken in a great number of pursuits, scientific, literary and philosophical. In fact, the truly educated man never suffers from ennui, is never at a loss for interesting mental diversions. If wisely directed, the well educated mind ought never to wear out, never even to become prostrated.

We wrote some years ago in these columns on "Hobby-Riding." Happy is he who has good hobbies, and knows how to ride them gracefully. No man needs them more than the busy doctor.

But for the patient, as well as the doctor, a prescription of "R. Diversion, q. s.," is at times invaluable.

There are many cases in which the mind is apathetic, the secretions are sluggish, the appetite fails and no drug seems able to oppose any resistance whatever to the bodily decline. In such cases often a new hobby, a new form of emotional excitement, best of all, a change of climate and associations, will

effect a cure, and render unnecessary the unpleasant alternative of a new doctor.

### CERVICAL DYSMENORRHOEA.

In the *British Medical Journal*, May 27, Dr. Hanfield Jones, after a careful study of the extensive records of such cases in his public and private practice, presents a brief summary of the varieties of dysmenorrhœa.

*Neuralgic Dysmenorrhœa* is first considered; this heading embracing those cases in which the dysmenorrhœa disappears when the patient is under favorable hygienic circumstances and reappears when unfavorable conditions are resumed. The trouble is here evidently of a neuralgic rather than of an organic nature.

*Inflammatory Dysmenorrhœa* is next discussed. In most instances the patient has had recent or remote inflammation of the pelvic organs or tissues, which ache whenever the menstrual congestion of the pelvic blood-vessels occurs, the aching beginning constantly two or three days before the flow and becoming more intense; until the flow, if free, somewhat relieves it.

*Membranous Dysmenorrhœa* is mentioned merely in passing by.

The form particularly under discussion, "*Cervical Dysmenorrhœa*," is carefully considered. The causation of the pain in this class of cases is obscure, yet it seems to be associated with certain abnormal conditions located principally at or near the internal os. The titles often used—"mechanical," "obstructive," "spasmodic"—are ill-chosen; for there is no proof that any mechanical obstruction or irregular spasm is present. After elaborate consideration of opinions

of eminent writers and of his own experience Dr. Hanfield-Jones comes to the conclusion that at the beginning of the monthly period uterine contractions set in which gradually produce dilatation of the whole cervical canal. Menstruation is in fact a diminutive labor, the time before the flow corresponding to first stage of labor, the onset of flow corresponding to the expulsive stage. In normal women both the first stage of labor and the preparatory stage of the monthly period are free from severe pain. A number of cases are adduced in which it was found that the internal os was wide open during the menstrual flow, closed gradually during the week following the termination of the flow, and was quite tightly contracted during the week before the next period commenced.

Why then is menstruation so often attended by severe pain in the women of the present day? In reply, four causes are adduced.

*First:* Malposition, and especially retroflexion of the uterus. The difficulties of the first stage of labor in the uterus displaced forward are met with to a less intense degree in such non-pregnant displacements. The relief gained from a well-fitting pessary strengthens this explanation.

*Second:* Muscular spasm of the sphincter fibres of the internal os. This condition, probably uncommon, would naturally be relieved by spasm-controlling drugs. And we do indeed find that chloral and even belladonna give great relief in cases where this variety of dysmenorrhœa has been diagnosed; just as they relieve in spasm of the cervix during the first stage of labor.

*Third:* Fibroid thickening at the level

of the os internum. This may have been produced by various causes, as chronic inflammation, or the scarring or suturing of cervical tears. In these cases the passage of the graduated dilators is quite difficult, but the canal once thus dilated is quite slow to contract, and until it does so, great relief is obtained from the agonizing monthly pains. The pain begins before the flow and lasts partly through the flowing period. Drugs do no good at all in these cases.

*Fourth:* Hyperæsthesia of the nerve-endings at the level of the os internum. This is generally associated with endocervicitis or endometritis, and is then benefited by leeching, saline aperients, hot douching, and local application of carbolic acid or iodised phenol. When no local inflammation is evident rapid dilatation of the whole canal speedily relieves. A very slight dilatation will greatly relieve the intense sensitiveness.

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### Books and Pamphlets Received.

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*Cholera: Its Prevention and Treatment;* by ELMER LEE, M. D., Chicago, Ill. Reprint from the *Chicago Clinical Review*, April, 1893. Also, in same cover, *Hydrogen Peroxide in Contagious Diseases—Cholera, Yellow Fever, Typhus and Typhoid Fever.* By CYRUS EDSON, M. D., Commissioner of Health, New York City. Reprint from *The Doctor of Hygiene*, April, 1893.

*A Study of Two Cases of Paroxysmal Sneezing, with the Treatment;* by WM. T. CATHELL, M. D., of Baltimore. Reprint from *Transactions Medical and*

*Chirurgical Faculty of Maryland.* Press of the Isaac Friedenwald Co., Baltimore.

*Inguinal Hernia in the Male;* by HENRY O. MARCY, A. M., M. D., L.L. D., Late President of the American Medical Association, Surgeon to the Hospital for Women, Cambridge, etc. Read before the Southern Surgical and Gynæcological Association, at Louisville, November, 1892.

*Remarks on the Presentation of Diplomas to the Graduating Class of the Barnes Medical College;* by C. H. HUGHES, M. D., St. Louis, President of Faculty and Professor of Neurology, Psychiatry and Electrotherapy. Reprint from *Alienist and Neurologist*, St. Louis, April, 1893.

### Medical Progress.

#### FEEBLE-MINDED CHILDREN.

The following encouraging note upon the education of these unfortunate ones is given in the review columns of the *Brit. Med. Jour.*:

The experience of those who have undertaken the education of the feeble-minded in Germany, Norway, Sweden and Denmark is very encouraging; in Christiania it is found that many of the pupils, after two or three years in these special classes, pass on to the ordinary school; some attain the standard prior to "confirmation," which everyone has to pass before going into any business or profession; some leave to go to special institutions for imbeciles; and some are ineducable, and after full trial are dismissed to their homes. It is interesting to know that the London School Board has now at work ten classes of these children, and the results have

already become so encouraging that it is intended to build special schoolrooms for them. The Leicester School Board has also a class undergoing special education.

#### DIABETES MELLITUS.

A full and able review of the nature and treatment of this important disease is given by Dr. Harley in the *Brit. Med. Jour.*, May 27th. He says:

As the presence of sugar in urine is not in itself a disease, but simply a sign which may arise from a multiplicity of morbid conditions, I think I am justified in making the five following nosological divisions of the subject:—

1. Hepatic diabetes—including the gouty variety.
2. Cerebral diabetes—including all cases of saccharine urine arising from nerve derangements.
3. Pancreatic diabetes—the most deadly form of the disease.
4. Hereditary diabetes—a form by no means uncommon, and one, too, where both brothers and sisters may labor under the disease without either their maternal or paternal parent having been affected by diabetes; though more distant members of the family may have suffered from it.

5. Food diabetes—including all forms of saccharine urine arising from the ingestion of unwholesome substances.

The presence of sugar in urine is due to a disordered animal chemistry, diabetes being, like gout, a chemical form of disease. As far as I am aware, however, there are but two ways in which the faulty bodily chemistry causes sugar to appear in the urine, and it was this belief that led me, no less than a quarter of a century ago, to divide all cases of



diabetes clinically, as well as scientifically, into two great and distinct classes. To the one I gave the name of diabetes from excessive sugar formation; to the other that of diabetes from diminished saccharine consumption — malassimilation.

Patients belonging to the first class are in general well nourished, and are so amenable to treatment that they may be kept alive and in comparative comfort for a quarter of a century and more; those belonging to the diminished consumption group are in general so little influenced by either medicines or diet that the vast majority of them succumb to the exhausting effects of the disease within a few weeks after its commencement.

Were I asked to give types of the two classes of the disease I would give hepatic diabetes as an example of that arising from excessive sugar formation, and pancreatic diabetes as that resulting from diminished consumption—malassimilation. It is with the former class alone I shall at present deal.

It may be well for me to mention that by far the most common cause of hepatic diabetes in temperate climates is the habitual use of stimulants coupled with rich foods. The reason of this is not far to seek, seeing that in 1853 I was fortunate enough to discover that animals could be rendered diabetic by the simple introduction of stimulants into their portal vein. So important were these results considered by the Society of Biology of Paris, to which I communicated them, that it appointed a commission, consisting of Professors Bernard, Wurtz, Robin and Verdeil, to report upon them. And lucky it was that the

Society thus stamped them with importance, as it is due to the information obtained from them, and the subsequent equally successful results of Bernard, who induced saccharine urine in animals by simply introducing stimulants directly into the duodenum, that the modern teetotal system of treating diabetic cases originated, which has done so much to reduce the mortality.

A temporary diminution of sugar in the urine is not an absolutely certain sign of improvement, since it may occur in diabetes during an acute disease, as typhoid fever; and it may occur in diabetes just before death.

As far as I am aware, no one has as yet ventured to explain this curious phenomenon, so I may as well give my idea of the matter, which is: (1) The sugar only disappears from the urine in the case of diabetes arising from excessive saccharine formation; (2) its disappearance is due to the depressing effect the superadded acute disease or injury has upon the sugar-exciting formative nerve power, precisely in the same way as nerve shock, either the result of mental emotion or physical injury, arrests the formation of bile.

#### TREATMENT.

Skim milk was thought by Dr. Donkin to fulfil by itself all the objects aimed at in restricting or totally excluding the use of farinaceous foods; but when milk is given, as given it may be freely, it is much better to give it fresh than skimmed. For in giving the latter you not only give all the saccharine matter, which normal milk invariably contains, but at the same time you deprive the patient of its non-sugar form-

ing, highly nutritious, oleaginous ingredients constituting the cream.

In the form of diabetes due to mal-assimilation it is necessary to supply to the body such easily assimilable foods as will retard emaciation, while they at the same time will keep up the vital powers of the patient. Hence in these cases, not only fresh milk, but cream, butter and even cod-liver oil should be given freely; and when greasy stools are met with, as in the pancreatic variety of the disease, from there being an absence of pancreatic juice, give also, along with the oil, either liquor potassæ or carbonate of soda dissolved in glycerine in order to emulsify the fats, and thereby render them more absorbable by the intestines. Not only so, but when the loss of flesh and strength is great, as it is not the presence of the sugar in the circulation but the want of its assimilation, which causes this (as by increasing the supply of the wanted nutritive material you augment the chances of its assimilation); do not hesitate to give freely the most readily assimilable saccharine substances, namely, honey and pure cane sugar. Kulz even recommends lævulose, the exact analogue of diabetic sugar.

For similar reasons, when patients suffering from excessive sugar formation begin to lose flesh and strength, and show signs of mental weakness, at once relax the severity of the restricted diet, and allow them toasted brown bread, along with fats and plenty of green vegetables and fruit.

Two different kinds of mineral water are useful to diabetics, the saline purgative, and the alkaline non-purgative

waters. The benencial action of purgative mineral waters is best seen in cases of diabetes from excessive sugar formation, and it is due to precisely the same cause as a restricted diet—namely, to reducing the saccharine supply. If the ingested food be swept out of the intestines before its nutritive ingredients have had time to be taken up by the intestinal absorbents, it might just as well never have been swallowed, in so far as furnishing materials to the liver to manufacture sugar with is concerned. Alkaline non-purgative mineral waters act by virtue of their alkalinity, in precisely the same way as liquor potassæ and carbonate of soda; namely, by emulsifying the fatty matters of the food and thereby increasing their absorbability by the digestive canal and thus conducing to retard emaciation and death. Hence their advantages are seen best in the diabetes from diminished consumption of pancreatic cases.

I now approach the most important form of liquid ingesta, the alcoholic. None but those having had much experience of liver diseases and diabetes can have the faintest idea of the powerful influence alcohol has in the production of both of them. It is not the drunkard, but the self-styled moderate drinker class which show this most potently. Of all the exciting causes of diabetes with which I am acquainted I give the palm to spirits. It matters little whether they be taken under the name of arrack, brandy, gin, rum, or whisky, their effects are identical; and, what is more, one often finds that diabetics, though not “nippers” themselves, come of a drunkard stock. Only in very exceptional cases do I advise in cases of diabetes the use of an alcoholic

drink, and that is, when weakness and loss of appetite show themselves in cases of diabetes from excessive formation, and increasing debility is a marked symptom in those due to diminished saccharine assimilation. Then and then only do alcoholic stimulants do good instead of harm.

As all diabetics suffer more or less from thirst, I am not one of those who prohibit their drinking bland liquids—tea, coffee, lemon squash, koumiss, soda, puralis, and Salutaris waters, as well as milk, with or without aerated water added, beef tea, bouillion fleet, bovril, and Liebig's extract. In cases where the thirst is annoying to the patient I bid him acidulate iced aerated water with a few drops of lemon juice or of dilute phosphoric acid, and slowly sip it. Phosphoric acid seemed to me to quench the cravings for fluids better than anything else.

First, as regards the drugs that act beneficially in diabetes the result of excessive sugar formation. These are all of the narcotic and anodyne class—opium, morphine, codeine, hyoscyamus, cocaine, bromide of ammonium and such like drugs. And they act, I believe, by virtue of the power which they possess of reducing hepatic nerve activity. This opinion is justified by reasoning from analogy, and the fact that the output of sugar is reduced during their employment. Opium, morphine and codeine do not always produce equally beneficial results in apparently identical cases, nor even in the same case at different times. Codeine, for example, may give unsatisfactory results where morphine is found potently useful, and, where both have failed, crude opium may

produce the desired effect. It is a common practice to go on augmenting the dose of the narcotic in proportion as it loses its beneficial effect. In this way patients have been given from 10 to 20 grains of codeine and from 20 to 60 grains of opium, in the twenty-four hours. This, in my opinion, is a highly reprehensible mode of practice, as I have more than once heard of cases in which it has been followed by disastrous results. Whenever I find  $1\frac{1}{2}$  grain of codeine or a couple of grains or so of opium for a dose producing little or no effect, either in reducing the amount of the urine or its specific gravity, I think the failure is most likely due to my not having selected the form of narcotic suited to the case.

The beneficial effects of croton chloral often surprise me, but I seldom or never give it except in combination with a vegetable narcotic or anodyne. As an example, in cases of diabetes the result of nerve depression, as well as those arising from pancreatic disease, I find strychnine of great service when given in the form of nux vomica extract in  $\frac{1}{4}$  gr. doses three times a day in a croton chloral pill combination. Indeed, it seems to me that everything tending in any way to improve the general health in such cases is of benefit to the patient. Hence not only strychnine and quinine, but likewise mineral acids—notably phosphoric and nitrohydrochloric—are of service. Antipyrin I once or twice found very useful, as well as occasionally the peroxide of hydrogen.

#### DANGERS OF VAGINAL PESSARIES.

Dr. Neugebauer, of Warsaw, has published an exhaustive analytical monograph on this question, so important



in these days when gynecology is widely practised by the surgeon and physician as well as the specialist. Two hundred and forty-two cases of injury have been collected and analyzed, five more being added in an appendix. Tabulating the results, Dr. Neugebauer presents the medical public with the following formidable statistical records. Twenty-three cases of perforation of rectum alone by the pessary; twenty cases of perforation of the bladder alone; ten cases of perforation of the bladder and rectum; one case of ureteric fistula alone; one case of ureteric and vesicovaginal fistula; one case of urethral-vaginal fistula; two cases of perforation of Douglas' pouch (neither fatal); three cases of perforation of the vaginal walls, the extruded portion of the pessary lying in the pelvic connective tissues; and six cases of entry of a vaginal pessary into the uterus.—*British Medical Journal*.

#### LONDON POST-GRADUATE COURSE.

Instruction will be given by the medical staffs of the following hospitals and institutions: The Brompton Consumption Hospital; the Children's Hospital, Great Ormond Street; the National Hospital for Paralysis; the Moorfields Ophthalmic; the Skin Hospital, Blackfriars; Bethlem Royal Hospital; the London Throat Hospital; the Bacteriological Department, King's College; the Parkes Museum; and the Central London Sick Asylum; besides a course of lectures on midwifery and diseases of women. The London Post-Graduate course has taken firm root as part of the system of clinical teaching of the metropolis, and it is so arranged that any visitor to London can, in a comparatively short space of time, obtain a fair insight into recent methods

of research and modern lines of treatment in the specialties dealt with. This year a series of vacation lectures on bacteriology and public health have also been given during the Easter holidays. As an example of the kind of work done we may describe the way in which the tubercle bacillus was studied. A lecture, illustrated by specimens, diagrams, and the lantern, was followed by an hour's practical work—in fact the hour was considerably exceeded—the kind readiness of Professor Crookshank and Dr. Hewlett to answer questions and explain difficulties. The tables, which run round two sides of the large laboratory, are divided into sections, each accommodating two workers and supplied with sink, water, gas, slides, cover-glasses, and the necessary materials for staining and mounting specimens. The plan of working in couples seems to offer great advantages, microscopes are economised, and men, driven by companionship, master little technical difficulties which might be slurred over in solitary work, besides which, in addition to the general sociability thereby introduced, conversation has a power, far beyond that of a lecturer, of fixing matters in the memory. During the hour each pair of workers stained and mounted several sections and specimens of tuberculous sputum, and we understood that the same practical work was carried on in regard to all the forms of bacteria which entered into the course. These vacation lectures, together with those on hygiene and public health which have been given concurrently at the Parkes Museum by Professor Wynter Blyth and Dr. Sykes, are examples of what the London Post-Graduate course, of which Dr. Fletcher Little is the energetic secretary, can offer.—*Ex.*

## GENERAL PYÆMIA FROM DECAYED TEETH.

A striking assertion in regard to the causation of chronic pyæmia is made by Dr. Hipple in the *Omaha Clinic* for June. He says: Physicians have not infrequently to deal with cases of chronic pyæmia in which abscesses form in various parts of the body and heal up only to break out again at other points more or less remote. That such a condition may result from a diseased tooth there can be no doubt—the virus from the seat of infection being carried by the blood or lymph to points which, for the time at least, possess the least powers of resistance. At first view it seems somewhat strange that an abscess in the toe may originate in a diseased tooth; but such is, undoubtedly, the case, and it naturally suggests that the oral cavity should be carefully inspected in all cases of chronic pyæmia the cause of which is not definitely known.

## LYMPHANGIOMA CIRCUMSCRIPTUM.

A case in point is reported by Dr. Noyes, of Melbourne, Australia, in the *British Medical Journal*, June 3. He writes: I can find but ten cases of this form of lymphatic disease on record, the notes of five of which have been published, and I therefore think the following worthy of record; it is also the first case of the kind reported from Australia. The patient, when first seen by me, was under Mr. Fitzgerald's care in the Melbourne Hospital, and I have to thank him for his courtesy in allowing me to take the following notes.

R. A., was a healthy looking well-developed girl, aged 12 years. Her mother died of phthisis; she had a brother and a sister, both of whom were perfectly

healthy. The patient stated that she had a small "birth mark" on the upper and front part of the right thigh, just below the fold of the groin. This remained quiescent till she was ten and one-half years old; at this period it began to increase slightly, and occasionally to bleed freely. From this date the small "water blisters" began to form. They appeared at first like small grains of boiled sago beneath the skin; subsequently they increased in size, some remaining discrete and others coalescing until the following condition was produced: At the upper and anterior aspect of the right thigh, immediately below the level of the fold of the groin, were eight distinct groups of vesicles, varying in size from a threepenny-piece to a shilling. The groups were composed, for the most part, of clusters of vesicles varying in size from a pin's head to a split pea. In color most of them were of whitish and transparent-looking like clusters of small white currants; others had a pinkish tint. Here and there some of the larger vesicles were filled with venous blood, giving the appearance of a ripe mulberry to the part. These dark lesions, however, were few compared with lighter ones. Between the groups the skin was beset with smaller pinhead-sized lesions, looking like grains of boiled sago beneath the epidermis. All the lesions were fluid in consistency, and by gentle pressure most of them could be obliterated, but they refilled immediately the pressure was removed. On pricking the light colored vesicles a transparent fluid, with an alkaline reaction, exuded. Over some of the older lesions the epidermis had become much altered, giving them a somewhat warty appearance.

As to the course of the vesicles when once they had formed, they seemed gradually to increase until they attained the size of a split pea, or larger. They had no tendency to spontaneous rupture. There were no subjective symptoms, and the general health was unimpaired. The size of the affected thigh was somewhat increased, it being about 2 inches larger in circumference, immediately below the seat of the lesions, than its fellow at a corresponding level. Below the knee the measurements were equal in both legs.

The treatment adopted was electrolysis, which has completely obliterated the vesicles on which it was practised. However, having recently (two years after the operation) had an opportunity of examining the patient, I find there are large numbers of minute vesicles in the neighborhood of the obliterated lesions. These have been developing gradually since the operation, but have never attained a larger size than that of a sago grain. The thigh has resumed its normal size, and is now equal in circumference to its fellow.

#### PSOROSPERMS IN CANCER.

In regard to certain specimens of alleged psorosperms presented to the Pathological Society of London recently by Dr. J. Jackson Clarke, the Morbid Growths Committee reports (*Lancet*, May 20th) as follows:

"We are unanimously of opinion that, notwithstanding the labor expended by the author on this subject and the feasible hypothesis or scheme he has framed, he has quite failed to prove his particular contentions. Certain of the appearances shown and described do not, it must be

allowed, at present admit of satisfactory interpretation, and we do not, of course, wish to imply that we exclude the possibility of some of these being hereafter proved to be stages in the life-history of a micro-parasite. The author, however, has not adduced any fresh evidence in support of this view. Other of the appearances, as previously stated, we hold to be distinctly misinterpreted. The author's attempt to show intermediate stages of development and a process of sporulation occurring in certain elements present in tumors has, in our opinion, failed. His so-called intermediate stages have often nothing in common nor do they always coincide in their staining reactions. Whether malignant tumors are due to micro-parasitic infection or not, the methods pursued by the author must be pronounced imperfect, uncritical and not calculated to advance, at least directly, our knowledge on this question. When reliance is placed solely upon histological appearances it is most important that these should be carefully checked by an extensive and thorough survey of the details of normal and pathological histology."

#### TREATMENT OF CHOLERA.

In the *Lancet*, June 3, Dr. MacLagan, after discussing the pathogenesis of cholera, writes thus of the treatment: The wonderfully restorative action following the injection of warm water into the veins in cholera collapse shows how much the symptoms of that condition are due to the want of water in the blood and tissues. The transitory nature of the improvement thus brought about shows how rapidly the water thus injected is used up. The injection of the water



supplies what the blood and tissues so much need; but it also supplies what the cholera poison so urgently demands and so quickly appropriates. In connection with this it is to be noted that these intravenous injections, though they remove for the time the symptoms of collapse, cause an increase in the bowel discharges.

Sir George Johnson believes, and supports the view with wonted ability, that contraction of the minute arteries, especially the pulmonary, is the cause of cholera collapse. That such contraction exists is most probable, but it is as a result, not as a cause; it is only part of the general cessation of functional activity consequent on the consumption of the water of the blood and tissues. The minute arteries are contracted because they are no longer stimulated to dilate; for it must be borne in mind that the state of activity of a minute artery is not contraction, but alternating contraction and dilatation, the dilatation being of the two the condition of greater activity.

One word on treatment. On this nothing that is satisfactory can be said. Under all methods of treatment mild cases seem to recover and severe ones to die. Two objects have to be aimed at in treating cholera; one is to check diarrhoea, the other is to prevent the partial arrest of metabolism which constitutes collapse from passing into the complete arrest of metabolism which constitutes death. The bowel lesion of cholera is peculiar; it may for practical purposes be described as an acute specific desquamative enteritis. Ordinary astringents are not of much service in such a condition. The per-salts of iron—per-sulphate, perchloride and pernitate—

given in full and frequent doses, are more likely than any other remedies to have a destructive action on the cholera poison and a healing action on the bowel lesion. The difficulty is their administration. Urgent sickness is so common a symptom in cases most calling for treatment that no remedy is retained. In the collapse stage medication by the mouth is of no avail. The injection into the veins of warm fluids is the only treatment which has ever really done any good. Its effects are often marvellous, but unfortunately they are not lasting. If collapse essentially consists in arrest of metabolism consequent on the consumption by the cholera poison of the water of the blood and tissues, to supply that which is lacking is the rational line of treatment. This can be done only by intravenous injections. It is possible that the want of success which has hitherto attended this treatment may be partly due to faulty method, founded on a mistaken idea as to its mode of action. In treating the collapse stage of cholera, as in treating the advanced stage of the specific fevers, it must be borne in mind that the object which is desired is not the arrest of the morbid process, but the keeping the patient alive till the disease has run its course. In advanced stages of fever this is done by giving beef-tea, milk, water and, if need be, stimulants. In cholera one cannot give anything by the mouth, but by intravenous injections one may be able to keep tissue metabolism from coming to a stop and so tide the patient through an illness which would otherwise be fatal. The best solution for the purpose would be a warm alkaline fluid containing some defibrinated blood al-

bumen. It should be given in quantity sufficient only to keep the patient going, care being taken not to give enough to lead to an increase of the diarrhœa. Nothing can prevent the cholera poison as well as the tissues from benefiting by the injections. The aim should be to keep the tissues going, trusting to be able to do so till the disease has run its course, till its poison ceases to be reproduced and till sickness and diarrhœa abate. The difficulty of treating cholera only brings into greater prominence what is, after all, the most important fact in the whole history of the disease—it is quite preventable. Out of the human body the cholera poison lives and grows in sewage-tainted water. Were water never so tainted, or were such water never used, cholera would never spread from Asia to Europe.

#### CHLOROFORM AS A HÆMOSTATIC.

In the *Medical Press*, April 5th, we are informed that as a general hæmostatic for the controlling of external bleedings, arterial, venous, or capillary, chloroform is most valuable. Applied on a dossil of lint or cotton wool to the bleeding surface, it promptly stays the blood, acts as a direct stimulant to the patient, and leaves no blood crust to fall off and recommence the bleeding. It is peculiarly suitable for all abdominal operations, as it has no tendency to excite inflammation either in the part to which it is applied or in any of the surrounding tissues.

As an antiseptic application it is more powerful than bichloride of mercury solution. The addition of gum resins has been suggested, but they would detract from the value of the application instead of increasing it, for the reason

which will occur to any person familiar with the use of solutions of gum resins.  
—*Epitome of Medicine.*

#### BERLIN STREETS.

As many as twenty-one different kinds of implements are employed, each having a particular use. Last year alone 23,323 large, stiff brooms were used, and 2,629 twig brooms, and the expenditure for implements for the year was \$59,420.

The horse-car companies are responsible for the cleaning of their tracks; but to simplify the matter, a careful estimate has been made of the area they cover, and the city cleans and sprinkles them, but the car companies pay two-fifths of the expense. By this arrangement all is brought under the control of the Street Cleaning Department, and cleanliness is insured where it would otherwise be neglected. It cost the city last year for cleaning the horse-car tracks \$28,429.

The street-sprinkling comes under this department. From April 1 to October 31 each year the watering-carts are on duty, and the most out-of-the-way corner is not neglected. The carts here are all cylindrical in shape, are painted bright scarlet, and have on them the capacity in litres, a litre being about a quart. The city possesses 166 carts, the majority having a capacity of about 400 gallons—some a little more and some a little less. All the streets are watered at least once daily in warm weather, and from personal observation, I can say it was well done. During the month of July, which was very hot, the streets were watered in many places three or four times, until the heated stones become thoroughly wet and cooled. In the year 1891-92, 205,127 cubic metres, of about

1.3 cubic yards, of water were used in sprinkling, at a cost of \$59,265.

The large area covered by the asphalt pavement necessitates the use of considerable sand, which must be strewn over the pavement in very wet or icy weather to prevent it from becoming dangerously slippery. Last year 7,548 cubic meters of sand were thus used.

To see the process of cleaning, with the exception of the brushing, which is going on all the time, one must be out late at night. Between midnight and 2 or 3 o'clock, when nearly all traffic has ceased, and only a solitary cab occasionally rolls by, the street-cleaners are on their beats in companies and are scraping and washing, scrubbing and brushing, until the middle of the street is as clean as the floors of the palace courts. There are three kinds of pavement used in the city—the common cobblestone, the Belgian and the asphalt. For thorough cleaning the cobblestone and Belgian pavements are simply brushed with stiff, heavy brushes, sometimes by hand and sometimes by large revolving brushes drawn by horses. The asphalt requires more elaborate treatment. It is first thoroughly brushed with stiff brushes, then thoroughly wet and all the dirt adhering to it is scraped loose; then again wet and gone over with long rubber scrapers, which sweep off the water and any remaining dirt.

Along all the streets at intervals are to be seen iron boxes, which are built to receive temporarily the dry surface sweepings which are gathered daily. A wagon goes around and takes this away as often as is necessary. The mud and manure are carried away in small iron two-wheeled hand-carts; the refuse

gathered in the nightly cleanings is carried off in large white iron carts, with tight lids. The removal of the refuse is in the hands of a contractor, who receives it from the city and finds his own methods of disposal. The manure is sold, and the remainder, after thorough disinfection, is used for filling in, etc. The cost to the city last year was \$132,138.

Overshoes are never needed to keep one's shoes from becoming muddy. One can walk a couple of miles in Berlin after a hard rain and find the shoes unsoiled over the edges of the soles. The sidewalks are always perfectly clean, and there are no crossings, for the entire street is as clean as the sidewalk. People cross the streets at all angles, and walk in them, and their boots are as clean at the end of the walk as in the beginning. To bring about this state of exquisite and extraordinary cleanliness last year \$452,249 was spent.

It was considered necessary to take extra precautions and to increase the working force as soon as danger from cholera appeared.—*Tennessee State Board of Health Bulletin.*

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### Medical Items.

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The University of Maryland School of Medicine has in hand important improvements. Practice Hall will be extended backward 20 feet to the rear of the lot and another story will be added. The first floor will be used as a chemical laboratory, the second floor for histological and pathological purposes; being fitted with tables, microscopes and other conveniences. A dissecting-room will



be provided on the third floor. The old dissecting room will be turned into a museum. The old lecture-rooms will be retained. The brick wall about the grounds will be replaced by granite coping; with the lawn put into order, this will give a very handsome appearance to the grounds.

The Anne Arundel Medical Society, which met in Annapolis July 12th, is growing in membership and its bi-monthly meetings are a source of much interest to the profession. The officers and members of the society are preparing for the semi-annual meeting of the Medical and Chirurgical Faculty, which will be held in Annapolis in November. Since the organization of the society, in 1890, several important subjects have been discussed by its members. The object of the society is the cultivation of medical science, and any member of the medical profession in good standing and residing in Anne Arundel County is eligible as an active member. Physicians outside the county may be elected corresponding members of the society. The officers and members of the society are: President, Dr. S. H. Anderson; vice-president, Dr. George Wells; recording secretary, Dr. B. B. Davidson; corresponding secretary, Dr. C. A. Henkel; treasurer, Dr. F. H. Thompson. Members—Drs. C. S. Johnson, Elijah Williams, Abram Claude, W. C. Claude, Thomas H. Brayshaw, J. C. McPherson, H. R. Walton, C. R. Winterson, George E. Marchand, S. D. Kennedy, W. G. Tuck, H. B. Gantt, C. Morris Cheston, H. M. Revell, W. Q. Claytor, George Hammond, J. W. DuBois.—*Ec.*

We are informed through the daily press of the death, on July 12, of Dr.

David Harlan, at the age of 84 years, at his home at Churchville, Harford Co., Md. Dr. Harlan was born near Stafford, in Harford County. He leaves four sons—Dr. Herbert Harlan, Judge Henry D. Harlan, of Baltimore, W. B. Harlan and David E. Harlan. He was a member of the board of visitors to the Naval Academy, at Annapolis, and a medical director in the United States Navy, and was one of the best known and most highly respected citizens of Harford County.

Dr. Harlan began the study of medicine in 1829 under Dr. John Archer, of Rock Run. He afterward attended the University of Maryland. He graduated in 1832 and located in Chestertown, Kent County, and practised there for three years.

He applied for admission to the United States Navy and was examined in 1835 and commissioned as assistant surgeon. In the spring of 1835 he sailed from New York on the Peacock to Rio Janeiro, around the Cape of Good Hope to Zanzibar, to Moscat, Bombay, Ceylon, Bangkok, Siam and Canton, China. While in Siam the Asiatic cholera broke out aboard the Peacock. Dr. Harlan had charge of the vessel and lost but one of the crew. Upon his return to the United States two years later he was presented with a sword by the members of the crew. In 1872 he was stationed at the naval hospital on the government farm at Annapolis. He was promoted to the rank of medical director in 1871 and upon reaching the age of sixty-two he retired. He built Trinity Protestant Episcopal Church at Churchville and was often a prominent member of diocesan conventions.

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### Original Articles.

## THE NECESSITY FOR THE EARLY RECOGNITION AND TREAT- MENT OF SUPPURATIVE DISEASES OF THE TYM- PANUM, AND THEIR RELATION TO CERE- BRAL COMPLI- CATIONS.\*

BY S. MACCUEN SMITH, M. D.,

Lecturer on Otolaryngology and Chief of Aural Clinic, Jefferson Medical College, of Philadelphia;  
Surgeon in Charge of the Ear and Throat Department of the Germantown Hospital, Philadelphia, etc.

In bringing the subject of this paper before you this evening it is with the hope that one of the many urgent subjects of otology may be so clearly presented, in connection with the discussion

which follows, as to deeply impress the busy practitioner with the importance of the early recognition and treatment of aural diseases in general.

We think it is an admitted fact that of all human ailments diseases of the ear have been the most neglected.

From the early days of medicine to the present time aural diseases have largely fallen into the hands of cunning quacks, who, through their hocus-pocus methods, have mystified the always gullible public. In fact, the science of otology has been reduced almost to the primitive teachings of the dark ages, when it was declared by the expounders of ancient wisdom that urine of the male and female, respectively, would cure ear diseases in the opposite sex, and that inflammatory conditions of the ear might be alleviated by one of their pharmaceutical special-

\*Read before the Philadelphia County Medical Society April 26, 1893.

ties, composed of "the delicate admixture of the excrement of pigeons and the ashes of horses' dung, to which might be added finely pulverized black pepper."

Judging from the statements of patients, there still exists among some of the profession a belief, largely shared by the laity, that something mysterious or magical surrounds the diseases of the ear and their treatment. With this opinion prevalent, we cannot express surprise at many of the unfortunate sufferers volunteering the information that they had been advised to "*Let well enough alone;*" "*it is bad to meddle with the ears;*" "*do not tamper;*" "*never heal a running ear or it will go to the brain and kill you.*"

It is also of daily occurrence to find that the syringe has been roughly used to throw a stream of water on an *exposed drumhead*, or that the popular but uncleanly habit has been suggested and followed of dropping greasy and other fungus-generating fluids into the ears.

This evident lack of information is, of course, due to the fact that in former years in many of our medical colleges otology had received only the minimum consideration, while in some institutions this most important branch of medicine had not even been mentioned in their curriculum. So long as students are not required to pass an examination on aural or other diseases it will be found that their knowledge of the same is almost *nil*.

It is indeed gratifying to be able to note the increasing interest and demand for special instruction on the ear and its diseases. To the recent graduate in medicine a knowledge of this branch now becomes imperative, as many of the State Examining Boards require applicants to pass an examination on otology.

From a medico-legal standpoint the subject is of the utmost importance, for certainly the time is not far distant when it will be regarded as illegal for one to so neglect a suppurative disease of the tympanum (either acute or chronic) that fatal cerebral complications result therefrom. Brain abscess and meningitis, as the result of ear diseases, are in the great majority of cases preventable. It, therefore, becomes the imperative duty of every practitioner of medicine to properly diagnose and treat such cases. This duty is especially important to the physician of general practice, inasmuch as he is usually the first to be consulted, and his direction and care of the patient at that critical time is often of vital importance.

In order to give an idea of the importance of ear diseases in their relation to general medicine and the responsibility and duty of the profession at large to the public, it will be interesting to note that it has been estimated by various authors that from 43 to 76 per cent. of all brain abscesses arise, either directly or indirectly, from suppurative disease of the middle ear. To this I should like to add that the same figures would probably not exaggerate the large number of cases of meningitis and pyæmia which, on account of their doubtful etiology, are termed and accepted as "obscure." Barker, as quoted by Keen and White, estimates that not far from two thousand deaths, caused by diseases of the ear, annually occur in Great Britain, with a population of little more than one-half that of the United States.

These are, indeed, impressive figures, and are especially deserving of serious consideration, from the fact that there are annually dying in the United States



probably four thousand of her inhabitants from brain abscess, the direct cause of which is some pathological change in the ear. Our belief is that should these cases receive early recognition and proper care the mortality, at least, would be greatly reduced and the fatal complications in most cases be prevented.

As a rule, an acute inflammation of the tympanum is painful in the extreme; and yet it must not be forgotten that we will at times find a case where the membrana tympani will rupture with the consequent flow of discharge, which will be the first and only symptom to attract the patient's attention. These cases, however, yield promptly to treatment, unless dependent upon some enfeebled condition of the constitution. On account of the symptoms not being urgent they attract but little or no attention, and, therefore, are allowed to form a good foundation for a chronic purulent suppuration with all its possible serious consequences.

An acute suppurative otitis media is usually the result of the acute non-suppurative variety (commonly known as earache) the symptoms of which briefly are, a sense of fulness in the head accompanied by more or less tinnitus and so called "neuralgia." In my experience these symptoms precede the real pain several hours, or in some cases it may be several days. The pain, which is very severe, generally occurs at night, and is referred to the ear and along the Eustachian tube. In most cases considerable fever is present, and marked impairment of hearing. As the pus accumulates, the bulging outward of the membrana tympani correspondingly increases, and the tension resulting therefrom in-

tensifies the pain almost beyond endurance. It is in this state or stage of the disease that immediate relief is so earnestly demanded for the present and future welfare of the unfortunate sufferer.

Should the patient have the good fortune to have the distended drum promptly punctured in order to promote the free escape of pus, and this followed by gentle inflation through the Eustachian tube, together with general antiseptic care and the use of leeches, the hearing will in most instances be quickly recovered, the discharge will cease, and all the functions of the organ will soon be re-established.

If, however, the pus is not promptly evacuated the patient is in imminent danger of one or more of the serious consequences that follow such neglect. Should the drum be so thickened and bound down by adhesions as to enable it to resist the pressure, as is sometimes the case, the pus will then, by one of the several means of communication, produce a septic inflammation of the brain or its coverings, which usually has the result of a prompt fatal issue. Or the pus may communicate with the mastoid antrum, thence to the mastoid cells, thereby subjecting the patient to all the serious, and oftentimes fatal, complications of such a condition.

Fortunately, however, these implications are not of frequent occurrence from acute suppurative otitis media, for, in neglected cases, nature has wisely provided a drum that will usually rupture of its own accord when the pressure from accumulated pus reaches the dangerous point; or, as it occasionally does, the pus finds an exit through the Eustachian tube into the throat. This is particu-

larly the case in children, because the calibre of the tube is proportionately much larger in early life.

Brain and mastoid implications arising from a suppurative inflammation of the ear are in nearly all cases a result of the chronic variety, although I have seen several fatal cases from the acute suppurative form. There is usually a history of chronic discharge, frequently even extending over many years. At times the "running" will cease, and the physician and patient (if he be under treatment) will congratulate themselves on the apparent success of their therapeutics, when quite unexpectedly the patient again applies for relief from a severe pain in the ear, caused either by exposure to cold or to wet, or it may be from some trivial accident, such as a slight blow upon the ear or head.

Any patient suffering from a suppurative otitis media, be it of the continued or recurrent form, is in constant danger (either from exposure to cold or traumatism) of a fatal termination. "Many apparently unaccountable cases of fatal coma are explained in this way: an old cerebral abscess, which has already lasted weeks or months without giving rise to any definite symptoms, suddenly giving way and bursting into the ventricular or subarachnoid space." It is, therefore, a safe and wise rule, as well as duteous teaching, to regard every person with a discharging ear as being in such a condition that serious, or even fatal, complications may arise on the slightest provocation.

Recent bacteriological investigations demonstrate beyond question that the quantity and especially the quality of the discharge is an all-important factor

in considering the prognosis of individual cases. The popular impression is that so long as a discharge is copious and devoid of fœtor it is harmless, and of such little moment as to demand treatment only from a point of tidiness or inconvenience. This belief, notwithstanding its almost universal acceptance, is misleading and is calculated to cause in the future, as it has done in the past, much misfortune.

It is entirely true that in a freely "running ear" we have present the best possible condition to prevent brain complications, and yet we must not lose sight of the fact that a decrease in the discharge, and especially if it should stop suddenly, must be viewed with some degree of alarm, inasmuch as this sudden or more gradual decrease in the flow is frequently caused by inspissated masses of mucus and pus collecting behind a wall of dried and hardened epithelium intermixed with pus, and entirely occluding the opening in the ruptured drum, consequently preventing the escape of discharge which continues to form until the accumulation causes much pressure, and the brain or mastoid complications may be the result.

Generally speaking, a discharge of pus without fœtor is considered harmless, and, therefore, in most cases receives little or no notice, unless for cosmetic purposes. Although the number of observations on the pathology of the putrefactive changes within the ear have been limited and confined to the researches of only a few investigators, sufficient information is at present made known from the recent discoveries in micro-biology to establish the fact that non-fetid pus from the ear contains

large quantities of pathogenic cocci, and is, therefore, highly infectious and dangerous to life. In fetid pus it is true that cocci are also found, but they are of the diplococci variety, and the bacilli which are also present largely predominate.

Barker, who has given this subject much thought and study, writes as follows: "From his inoculations of animals with cultivations and pus emulsions Rohrer came to the conclusion that the various forms of bacilli found in the fetid secretions of the ear were not pathogenic but simply saprophytic, the animals inoculated with the bacilli either in the tympanic cavity, the auricular veins, or the peritoneum, being alive and well at the end of some months, little or no action having taken place locally. But of the pathogenic nature of the cocci there could be no doubt, from his experiments on animals; typical septic diseases of various kinds being produced without fail. These observations appear to me to possess a special interest as regards the question of fetor from the ear. It has been commonly taught hitherto that a bad smell from the ear is an important factor in the prognosis of aural inflammations. My own observations, however, for a long time past have led me to question this conclusion very seriously, and to hold and teach that some of the most dangerous sequelæ of otitis media may be met with where the secretions from the tympanum are either nearly or quite odorless."

"If this be true, and I fully believe it to be so, the explanation is found in Rohrer's observations regarding the pathological cocci found alone in the non-fetid discharges, and the preponderance of merely saprophytic bacilli in the fetid.

We must not, therefore, think the less seriously of a discharge from the ear because it is odorless, but must endeavor to get rid of its exciting cause just as strenuously as if it were most offensive. This is only what we might expect from an experience of ordinary suppurating wounded surfaces in other parts, which in many cases give rise to serious or fatal septic complications without giving off any fetor."

Caries and necrosis are a frequent and serious complication of suppurative otitis, and are produced by ulceration of the inflamed mucous membrane of the tympanum, by extending to the deeper layers of that membrane (which act as the periosteum on the inside of the osseous cavities) and finally attacking the bone itself.

Politzer describes the process as "an infiltration of round cells into and around the fibrous tissue which penetrates the substance of the bone as offshoots from the mucous membrane. These round cells may undergo three transformations: they may break up and be absorbed, they may be converted into connective tissue in which depositions of lime may take place, and we then have a thickening of the bone, or they may, by degeneration and erosion, produce an ulcerative osteitis. This ulceration may be due to constitutional taint, or to retention and decomposition of secretion, or to the catarrhal ulceration and wasting of the mucous membrane."

As the carotid canal (through which passes the carotid artery) forms the anterior wall of the tympanic cavity, and the jugular fossa (in which lies the bulb of the jugular vein) constitutes the floor of the tympanum, it will be readily seen why dangerous and even fatal hæmorrhages



rhage may occur as the result of caries and necrosis of the middle ear. The bony walls of the tympanum are always thin, and in some cases the roof is entirely absent. The middle and back part of the temporo-sphenoidal lobe and the outer and front part of the lateral lobe of the cerebellum are in direct contact with the middle ear. Knowing this intimate relation of the tympanic cavity to the brain to exist, it does seem surprising that many more fatal results from inflammatory diseases of the temporal bone are not recorded.

As the skin of the external auditory canal (being somewhat modified) is continuous with and forms the outer layer of the membrana tympani, suppurative otitis media may be set up from without as well as by infectious matter reaching the tympanum through the Eustachian tube, the mucous membrane of which is continuous with that of the throat and forms the inner layer of the drum. And, as many of the mastoid cells lie below the level of their opening into the middle ear, and the floor of the tympanum is in part below the orifice of the Eustachian tube, it will be seen how a suppurative disease of the tympanic cavity, or even the mastoid cells, may continue in a chronic state for months or years.

In suppurative otitis media brain abscess may be induced by direct continuity of structure, or the infectious matter may be communicated to the dura mater, causing subcranial abscess or diffuse meningitis, or to the bloodvessels in the diploe, giving rise to osteo-phlebitis, thrombosis of the lateral sinus, or pyæmia. Or, as is the case in suppurative otitis externa, likewise in neglected otitis media, the pyogenic germs may find their

way between the opening formed by the non-union of the vaginal and mastoid processes, thus producing a superficial mastoid abscess.

Through carious involvement of the malleus and incus there is frequently a direct communication between the tympanum and the mastoid antrum and cells, this being the usual way in which pus invades these cavities and forms a true or deep mastoid abscess.

There are many other routes along which the infection may travel; it may extend through the hiatus fallopii or the aqueductus vestibuli, or down the internal auditory meatus, or it may extend along some of the numerous small veins which run between the internal and middle ear, on the one hand, and the dura and pia mater on the other.

I will now briefly relate one interesting case of mastoid disease following an acute suppurative otitis media.

On March 26th, 1892, I was called to see Mrs. L. B. and found she had been suffering from a severe pain in her left ear and head for two weeks. On inspection nothing could be seen that would suggest a forming abscess of the middle ear, and as the pain in the head was so general it quite deceived the attending physician. On examination through the meatus we found a greatly inflamed drum and bulging of Shrapnell's membrane. We immediately opened the drum, which allowed a free escape of pus and greatly relieved the patient's pain. This was followed by leeches in front and blisters behind the ear; after which hot poultices were applied to promote supuration. From this line of treatment entire relief was obtained for five weeks (but the ear continued to discharge),

when pain was complained of over the mastoid; in fact, it involved the entire left side of the head.

The usual active measures were at once adopted to relieve pain, but the brief cessation of suffering was only while under the influence of drugs. (It is well to state that neither the mastoid nor any part of the head showed any evidence of either redness or swelling.) Three weeks later she expressed her willingness to submit to an operation, and with the kind assistance of Dr. J. M. Barton, I opened the mastoid cells, evacuated the pus, and found, by using the syringe, that the opening in the mastoid communicated with the external auditory canal. This established perfect drainage, which relieved the patient of all pain and discharge, but the hearing was found to be destroyed.

In August we removed the drum and ossicles, which resulted in the almost immediate restoration of her hearing, which remains normal at this writing.

As all inflammatory conditions and abscesses of the brain are most serious, and especially so when dependent upon diseases of the temporal bone, it, therefore, becomes our imperative duty to make every effort to prevent these unfortunate complications, rather than to hope for their relief after having once developed.

It is not the object of this paper to enter into the subject of treatment from a general surgical point of view, but simply to offer such suggestions as are thought to be in a measure preventive, for it must now be admitted that many of the serious complications arising from diseases of the ear have much to commend the probability of their being preventable. As already shown, the majority

of brain and mastoid diseases are due to a suppurative disease of the tympanum, and are usually the result of the chronic form of discharge.

Most cases when applying for treatment give the history of a "running ear" extending over months or years, and that it has resisted treatment in the hands of many competent physicians. In cases of chronic discharge from the ear that do not yield to due and proper care it is now our rule to advise the removal of the drum and one or more ossicles.

By this surgical procedure we establish a free drainage and make an opening into the tympanum sufficiently large to admit of the site of the disease being properly treated by antiseptic washes and applications, and if this interference be established before brain or mastoid complications have set in, these developments will almost surely have been prevented; besides, the discharge in nearly all cases will cease, and the hearing in the majority of patients greatly improve, while in others it becomes quite normal.

Or, if you have a case presenting symptoms of cerebral irritation or abscess where there is a chronic "running ear," and it does not yield promptly to the above measure in conjunction with leeches to the mastoid, etc., it may be due to pus confined in the mastoid antrum, and no time should be lost in making an incision over the mastoid and trephining the same half an inch behind and above the centre of the external meatus. Within the past year I have seen five cases relieved by this method of treatment. In suspected mastoid disease an incision down to the bone is often delayed too long, and, perhaps, is never done too soon.

TWO CASES OF AMPUTATION AT  
SHOULDER JOINT, IN WHICH  
WYETH'S PINS, TO CON-  
TROL HÆMORRHAGE,  
WERE USED.\*

BY JOHN. H. BRINTON, M. D.,  
OF PHILADELPHIA.

CASE.—*Osteitis deformans of the leg, followed at the expiration of twenty three years by sarcoma of the humerus; amputation at shoulder joint by the oval method; use of Wyeth's pins to control hæmorrhage; death on the tenth day.*—E. B., aged forty-eight years; born in Massachusetts; publisher. About twenty-three years ago he noticed tenderness over the right tibia, increased by pressure, by severe or prolonged exercise, and barometric changes. Various anti-rheumatic measures were employed, but without avail. The limb did not become much worse; he was able to be about and follow the business of his life for years. During this time he was not lame, but experienced a sense of weakness in the limb. To use his own expression, "he favored that leg." In the course of years the bones of the leg had gradually increased in thickness, and had become curved. About ten years ago he consulted the late Professor Agnew, who told him that he could do nothing to relieve his slight disability of the limb, and that the affection was incurable. About three years since he consulted me, but I could add nothing to what had already been said, and could suggest no treatment.

In November, 1891, the patient consulted me for a fracture of the body of the left scapula. This resulted from a fall backward as he was descending from

the step of a railroad car, the scapula striking the edge of a projecting board or plank. This fracture healed rapidly and well.

In June, 1892, in jumping from a street car while in motion, and while his hand grasped the railing, he experienced great pain just below the right shoulder, and felt that the arm was broken. He came directly to my office. On examination, I detected crepitus, diagnosed fracture of the anatomical neck of the humerus, and treated him for that injury. Union took place quickly, and full use of the limb was obtained. The only noticeable feature in this injury was the occurrence of slight pain referred to the outside of the humerus, about the lower portion of the upper third. There was at that time no enlargement of the bone at this locality.

On September 19, 1892, the patient again consulted me, stating that a "lump" had appeared on the outside of the humerus at its upper part. I examined the arm and found distinct cylindrical enlargement of the humerus, obviously a sarcoma of the bone, and I stated this to the patient, advising him to consent to the removal of the limb at the shoulder-joint, if the diagnosis should be confirmed by a preliminary incision. At the patient's request, Drs. Packard and John Ashhurst saw the case in consultation, and they agreed with me in the propriety of immediate operation. From a careful examination of the patient's entire clinical history, there was no doubt in our minds that the case was one of osteitis deformans, first described by Paget, and which had been followed, as is so often the case, by the development of a malignant growth.

\*Read before the Philadelphia Academy of Surgery.



The operation was fixed for October 5, 1892, but at the preliminary shaving of the axilla, and preparation of the limb, or by the patient's lifting of the limb, fracture, which may fairly be regarded as spontaneous and non-traumatic, occurred, as was made evident at the time of operation, done in the presence and with the assistance of Drs. Keen, Ashhurst, Packard, and others.

To prevent hæmorrhage, the long steel pins of Prof. Wyeth were inserted by Dr. Keen, the anterior one transfixing the anterior axillary fold in front of the vessels, penetrating the tendon of the pectoralis major muscle, and emerging near the end of the acromion.

The posterior needle pierced the deltoid and emerged just below the acromion. By carrying the needle, especially the anterior one, well upward, the constricting rubber band was placed so high as not to prevent the rotation of the humeral head, or to interfere materially with its disarticulation.

This patient suffered very slight loss of blood at the time of the operation, and received but little shock. He reacted promptly and perfectly, and for several days did well, the wound uniting throughout. On the night between the fifth and sixth day the temperature rose to  $104.5^{\circ}$ , and a copious eruption, similar to that of measles, appeared on the abdomen and chest, and eventually invaded the extremities, and indeed the whole body. There was marked coryza, and the tongue became brown and dry. This condition resisted all treatment and the free use of antipyretics. As the eruption spread, the temperature still rose, reaching  $107.5^{\circ}$  and  $108^{\circ}$ , and the patient died on the afternoon of the

15th of October, the tenth day after the operation. The intellect remained clear until within an hour or so of the end.

I cannot but regard the death as due to some form of septic infection not easy to determine.

It is unnecessary to add that the anti-sepsis was observed in the treatment before, during, and after the operation.

The specimens, showing the sarcoma of the shaft of the humerus, and the peculiar indented fracture of its head and anatomical neck, are before this Academy. I particularly desire the observation of the Fellows to the fracture, which appears to me to have resulted from violent impact of an infiltrated diseased caput humeri against the edge of the glenoid cavity.

CASE II.—*Amputation at shoulder joint for enchondroma of humerus.*—The other case of shoulder amputation, in which I used Wyeth's pins, was that of a boy (I. B.), from Vermont, ten years of age. Nearly a year previously a tumor, apparently an enchondroma, began to develop on the inner side of the humerus, close to the head of the bone. It eventually grew until it attained a diameter of two and a half inches. It was painless, but interfered with the joint-motion by its bulk. The boy was brought to the clinic of the Jefferson Hospital, and after consultation with my colleagues, I determined to remove the arm at the shoulder.

This was according done on the 28th of November, Wyeth's pins being first introduced by my colleague, Professor Keen. The anterior pin was made to emerge three-quarters of an inch above the tip of the acromion. As a result the circular turns of the tubing rested on a

somewhat higher level than in the preceding case. Perfect freedom of the joint was preserved, and its disarticulation was not unimpeded. Previous section of the bone with the saw, as directed by Professor Wyeth, was not necessary. A roller bandage was applied as a compress under the tubing and directly over the artery. Hæmorrhage was thus perfectly prevented, and the removal of the limb, as in the former case, was practically a bloodless procedure. This boy recovered without accident.

I may state that in both these instances an Esmarch elastic bandage was applied previous to the insertion of the pins.

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### **Society Reports.**

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#### **ANNE ARUNDEL COUNTY MEDICAL SOCIETY.**

The Anne Arundel County Medical Society met in the Maryland Hotel, at Annapolis, July 11th, in regular bi-monthly session. Dr. Samuel H. Anderson, of Woodwardville, President, and Dr. B. R. Davidson, Secretary.

A very interesting and instructive paper on "Acute Bright's Disease" was read by Dr. H. M. Revell, of Arnold's, and discussed by members generally.

A vote of thanks was tendered Dr. Revell for his paper.

Several interesting cases were reported by members.

The Corresponding Secretary, Dr. C. B. Henkel, reported the acceptance, by the Medical and Chirurgical Faculty, of the Anne Arundel County Medical Society's invitation to hold their semi-annual session in Annapolis, and that November

21st and 22nd were appointed by the Faculty as the days for the meeting.

A committee was appointed by the Society to make arrangements for the coming convention of the Faculty, the committee consisting of Drs. Geo. Wells, C. B. Henkel and F. H. Thompson.

The members present were: Drs. Abram Claude, Anderson, Wells, McPherson, Thompson, Revell, Davidson, Cheston, Williams and Henkel.

CHAS. B. HENKEL, M. D., Cor. Sec'y.

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The *Review of Reviews*, which is fitly entitled "The Busy Man's Magazine," presents for July, 1893, a very attractive number. Prominent among its able articles are accounts of interesting features of the Chicago Exposition as the peculiar genius of the American people unfolds itself there to the gaze of the foreigner; pen-sketches of Edison, the great American electrical inventor, and Sir William Thompson, the famous Scotch electrical scientist; and side by side with such sketches thoughtful reviews of the great monetary and other problems with which civilized nations are now confronted. A general epitome of the world's progress fills out the measure of this great journal's completeness.

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Dr. J. Allison Hodges, of Wilmington, N. C., has accepted the invitation recently extended him by the faculty of the College of Physicians and Surgeons, of Richmond, to fill the chair of anatomy in that institution.

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The American Medical Association will hold its next annual meeting in San Francisco.

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BALTIMORE, JULY 22, 1893.

**Editorial.**

**THE JOHNS HOPKINS MEDICAL SCHOOL.**

Having in youth entertained hopes of receiving a medical education in this school, and having year after year seen our expectations fade into the realm of the vast unfulfilled, we now, when gray hairs and increasing responsibilities are attesting the fact that it is forever too late for us to enjoy its advantages, take pleasure in announcing to a younger generation that the first circular of the school lies before us, full of interesting promise of the coming winters' work.

The corps of teachers who are to direct the first year studies (of its four-year curriculum) during 1893-94 is in every way excellently chosen. The professorial chairs have been filled as follows: Pathology, Wm. H. Welch, Dean; Chemistry, Ira Remsen; Principles and Practice of Medicine, Wm. Osler; Psychiatry, Henry M. Hurd; Surgery, Wm. S. Halsted; Gynecology and Obstetrics,

Howard A. Kelly; Anatomy, Franklin P. Mall, late of the University of Chicago; Pharmacology, John J. Abel, late of the University of Michigan; Physiology, Wm. H. Howell.

The Associates are: Bacteriology and Hygiene, George H. F. Nuttall; Pathology, Simon Flexner; Surgery, John M. T. Finney; Gynecology, Hunter Robb; Obstetrics, J. Whitridge Williams; Bacteriology and Hygiene, B. Meade Bolton.

The Lecturers are: Diseases of Children, Wm. D. Booker; Nervous Diseases, Henry M. Thomas; Laryngology, John N. Mackenzie; Genito-Urinary Surgery, James Brown; Ophthalmology and Otology, Samuel Theobald; Psychiatry, Henry J. Berkley; History and Literature of Medicine, John S. Billings.

As assistants to the preceding are Lewellyn F. Barker, Pathology; Wm. S. Thayer, Medicine; Joseph C. Bloodgood, Surgery; J. Williams Lord and Thomas C. Gilchrist, Dermatology; Robert L. Randolph, Ophthalmology and Otology; and Albert L. Stareley, Gynecology.

We cannot enter more fully into details of the curriculum. The school is open alike to both sexes, without reservation or distinction.

The lecture and clinical courses given at the hospital during the last few years to physicians will be continued as before, in dispensary, laboratory and operating theatre.

The fees for the first year in the Johns Hopkins Medical School will be \$200. The second year's instruction is not provided for. Inquiries should be addressed to the Registrar of the Johns Hopkins University, Baltimore, Md.



DR. FRIEDENWALD ON THE  
INTERRUPTED BLOOD  
COLUMN.

Forty years ago Dr. Jäger called attention to the existence of this peculiar phenomenon in the arteries and veins of the retina in a case of sudden blindness. He described it as a more or less rapid, interrupted, non-rhythmical progression of the unevenly colored blood current.

It has since been observed by several other workers, generally in connection with embolism of the central artery of the retina.

In the *Ophthalmic Review*, of London, June, 1893, Dr. Harry Friedenwald, of Baltimore, describes his own observations upon this phenomenon in several different forms of eye disease and in different parts of the eye-globe. He says:

I have seen it in several cases of embolism. The most exquisite case which has come under my observation was one of embolism of the superior trunk of the central retinal artery. The patient—a young lady about 25 years of age—was under my care in 1888, while assistant to Professor Hirschberg in Berlin. One eye had been blind for several years—the result of embolism. She presented herself with embolism in the other eye within twelve hours after its occurrence. Even at this time there was considerable œdema of the retina. The superior trunk of the central artery was almost empty (that is, of red contents) up to its division into the superior nasal and temporal branches. It was white except in the middle, where there was a minute red cylinder, making slight vibratory movements synchronous with the pulse. In the superior nasal and

temporal branches the blood was broken into small cylinders—red and white alternating—which moved sometimes very slowly, sometimes rapidly (especially after massage of the eyeball). The current moved continuously from the superior temporal branch into the nasal; it was centripetal in the former, centrifugal in the latter.

I have also seen the interrupted blood current in glaucoma. The patient had simple glaucoma in both eyes with marked arterial pulsation, showing certain peculiarities. The right eye was completely blind, and upon it I tried the effects of great pressure in order to find how they accorded with those described many years ago by Donders. In Donders' experiments it was found that by pressing on normal eyes venous pulsation could be induced. Still greater pressure would establish arterial pulsation. In my case the glaucomatous tension was so high that there was already arterial pulsation, and I was curious to know the effect of pressure upon such an eye. I was much surprised at the result. The wave of pulsation became shorter and more abrupt as the pressure was increased; when the pressure was very high the arterial pulse-wave resembled a flash of red, which immediately vanished, leaving the arteries quite empty and very thin—and it was then that the veins showed broken columns of blood similar to those described above in the case of embolism. They moved slowly toward the papilla. As soon as the pressure was diminished they disappeared, and the vessel again seemed normal. This observation was made in 1888. I have recently found that Schnabel likewise noticed this phenomenon in glaucoma.

The moving broken blood columns have been seen in the conjunctiva and in the cornea. Donders observed them with the microscope by sunlight in the normal conjunctival veins. I was not aware of this when my paper on the "visible bloodcurrent in newly formed corneal blood vessels" was published.\* By means of a Hartnack's hand lens I found the same peculiar circulation in the blood vessels of the cornea in various forms of vascular keratitis, and also in the fine conjunctival vessels. It appeared to be in the venules; it is doubtful whether it is visible in the arterioles. The contents of the vessels seemed to be broken into small parts, in which small red cylinders alternated with colorless intervals. Both varied greatly in their length. The motion of the blood was not regular; it was sometimes continuous, then it would almost cease or stop entirely, or there would be sudden starts and stops.

The microscopic examination† of the pigs' eyes mentioned above shows that the colorless spaces contain no red blood corpuscles, or only a few scattered ones; these are collected into heaps in the colored parts. The colorless portions of the vessels are filled with blood plasma, and contain white corpuscles. There is no doubt, I think, about the colorless interspaces having the same composition in the living vessels.

It would appear that the circulating blood in the vessels breaks up into colorless and colored parts, into parts free from red corpuscles, and parts in which the latter become aggregated in masses,

and that this occurs when the current is greatly retarded. This explains its occurrence in all the instances cited above, and it would explain the fact that the phenomenon has been seen much oftener in veins than in arteries. The fact forces us to the conclusion that there is cohesive attraction between the red blood corpuscles, which naturally manifests itself only when the current is very slow.

### Pan-American Congress.

#### SECTION ON GYNÆCOLOGY AND ABDOMINAL SURGERY.

All members of the medical profession are cordially invited to attend the meetings of this section to be held in Washington, September 5, 6, 7 and 8.

The sessions promise to be exceptionally interesting, many valuable papers having been contributed. Those who may wish to read papers before this section and who have not yet sent in their titles and skeleton abstracts are requested to do so at once.

Papers have already been contributed by the following distinguished gentlemen from the United States and Canada: Drs. T. Johnson Alloway, Montreal, Canada; A. W. Abbott, Minneapolis, Minn.; J. M. Baldy, Philadelphia, Pa; H. J. Boldt, New York City; Augustus P. Clarke, Cambridge, Mass.; Ernest W. Cushing, Boston, Mass.; Andrew F. Currier, New York City; L. H. Dunning, Indianapolis, Ind.; Geo. R. Deane, Spartansburgh, S. C.; W. E. B. Davis, Birmingham, Ala.; Joseph Eastman, Indianapolis, Ind.; Geo. M. Edebohls, New York City; De Saussure Ford, Augusta, Ga.; William Gardner, Montreal,

\* Centralblatt für Augenheilkunde, February, 1888.

† In this Dr. S. Flexner kindly assisted me. I desire here to repeat my thanks for his assistance and valuable suggestions.

Canada; T. H. Hawkins, Denver, Col.; John R. Haynes, Los Angeles, Cal.; Edw. W. Jenks, Detroit, Mich.; Jos. Taber Johnson, Washington, D. C.; Howard A. Kelly, Baltimore, Md.; Florian Krug, New York City; G. Betton Massey, Philadelphia, Pa.; Lewis S. McMurtry, Louisville, Ky.; R. B. Maury, Memphis, Tenn.; Wm. F. Myers, Ft. Wayne, Ind.; E. E. Montgomery, Philadelphia, Pa.; Robert T. Morris, New York City; Chas. P. Noble, Philadelphia, Pa.; Jos. Price, Philadelphia, Pa.; Geo. H. Rohe, Baltimore, Md.; Jas. F. W. Ross, Toronto, Can.; Chas. A. L. Reed, Cincinnati, O.; I. S. Stone, Washington, D. C.; R. Stansbury Sutton, Pittsburgh, Pa.; T. Algernon Temple, Toronto, Can.; A. Vander Veer, Albany, N. Y.; W. B. Ward, Topeka, Kan.

Brooks H. Wells, 71 West 45th St., N. Y. City, English-Speaking Secretary.  
W. W. Potter, Executive President.

#### THE OPHTHALMIC SECTION.

With the object of making the work of the Section on Ophthalmology of the Pan-American Congress more interesting and instructive to the members, Dr. Julian J. Chisolm, the President of the Section, has selected the following subjects for study and discussion, in addition to the reading and consideration of the many papers which will be presented.

The subject for discussion on the second day of the meeting will be: "Muscular Errors: How to detect and correct them."

The third day of the Congress will be devoted to: "Refractive Errors: the best methods of diagnosis and treatment."

Those two subjects have been selected for special study because they confront us in our every-day work. Patients suffering with refractive or muscular errors fill our offices, and cause us much anxious thought. In fact such cases make up really a very large percentage of ophthalmic practice. Hence to view these subjects from the standpoint of a personal clinical experience with the new methods of investigation cannot fail to be instructive. Early notice has been given so that every one who may expect to attend the Congress can give some preparation and collate personal experiences, so that they may be able to illustrate their methods by facts. Individually we all need guidance over obstructive points which so often resist our best endeavors to relieve suffering, and restore eyes to painless usefulness.

Any papers pertaining to the assigned subjects will be read preliminary to the opening of the discussion.

It is hoped that the leading men of the Continent, interested in ophthalmic surgery, will try to be present, and will come prepared to give to others the benefit of their personal experiences and methods of practice.

#### EXCURSION TO ROME.

It has been definitely determined that the Pan-American Medical Congress Excursion to the XI International Medical Congress will sail on the S. S. "Werra" from New York, September 9th, the day following the adjournment of the Congress at Washington, and will arrive at Genoa, September 20th, four days before the opening of the Rome meeting.

Round trip steamer tickets may be procured for \$142.50 for inside rooms, and



\$150.00 and upwards for outside rooms. Tickets are good for members of the Congress and their families and may be used at option of holder to return on any steamer of the line from Genoa, or on Saturday steamers from Bremen, or Sunday steamers from Southampton, during the months of October, November and December. Physicians desiring to avail themselves of this exceptionally low rate should at once become members of the Pan-American Medical Congress by sending the registration fee (\$10.00) to the Treasurer, Dr. A. M. Owen, Evansville, Ind., and informing the Secretary-General, Dr. Chas. A. L. Reed, Cincinnati, of their intention to join the excursion. Passage should be secured without delay, as the trip, involving, as it will, a stop at the Azores and Gibraltar and a sixty hours sail along the picturesque coasts of Spain, France and Italy, promises to be very popular. Many prominent European guests of the Pan-American Congress will return on this occasion. The time allowed will afford American physicians an opportunity not only to attend the International Congress and visit Rome, but to extend their journey to the famous sanatoria of South France and the Riviera.

### Medical Progress.

#### RELIEF OF BOWEL AFTER ABDOMINAL SECTION.

In the *Pacific Medical Journal*, March, Dr. Haskin gives the following: The plan which I had the pleasure of seeing successfully tried in four cases with the permission of my attending surgeons at the Woman's Hospital, of New York, is

as follows: To introduce a soft rubber rectal tube about one-third to one-half inch in diameter into the rectum and through the sigmoid into the colon while the abdominal cavity is still open, thus being able to guide the tube positively with a finger in the abdominal cavity. The presence of this tube, which can be held in place by a bandage or strip of plaster around the thigh, insures a passage of gaseous matters from the colon and will also prevent any bending of the sigmoid upon itself from causing obstruction. The free end of the tube may be controlled by a thumb clamp of any description so that the escape of the gases can be regulated by the unseen charge.

In the four cases in which it was tried it was not the source of annoyance to any and certainly relieved all the symptoms caused by the distension of the bowel. The enema was injected through the tube and after being retained for a short time was accompanied or shortly followed by an evacuation of fecal matter. The tube was then removed and no disturbance followed, the time of retention being about 36 hours.

It is especially useful where there have been many inflammatory adhesions broken up or much disturbance of the broad ligaments. It lengthens the operation for a few moments but it insures an open track from the colon which cannot be closed by any inflammatory action or bending of the sigmoid upon itself. It is also safer, for the reason that you do not have to disturb the patient to introduce the bedpan under her when defecation takes place, as the fecal matter can all escape through the tube itself into any vessel.

EXPECTORATION OF BRONCHIAL  
CASTS AFTER HÆMOPTYSIS  
IN PHTHISIS.

An interesting article on this subject is given by Dr. Williamson in the *Lancet* of June 3d. He says:

In the *Lancet* of May 20th, 1893, an interesting paper was published by Dr. R. W. Richards calling attention to the occasional expectoration of bronchial casts after hæmoptysis in phthisis. The fact that such a condition can actually occur, however rare it may be, deserves fuller recognition; and, keeping in mind the difficulties between phthisical hæmoptysis on the one hand and plastic bronchitis on the other, every instance seems to be worth recording. I have before me two branching, tree-like clots, evidently casts of a medium-sized bronchus, and exactly answering Dr. Richards' description. They are both from one patient and they readily attracted my attention in examining the blood that had been expectorated. Slight and transient hæmoptysis last February was the first sign of anything wrong with a chest which Dr. Ord had pronounced healthy in the previous November. The hæmorrhage recurred early in March, and it was then that the casts were coughed up. Extending over nearly a week there were several sudden, copious bleedings of from two to six ounces, each occupying only a few minutes, then disappearing entirely for several hours at a stretch, to recur time after time in the same explosive fashion. The loss of blood which occurred amounted altogether to not less than two pints. A succession of explosive attacks of hæmoptysis, separated by several hours of freedom, is often taken to indicate a cavity with an aneurysmal dilatation in

its walls; but this need not be so; it can occur in the cases now under notice. In this individual patient there is no cavity. The disease at present (May) is limited to quite a small area at the left apex and still remains in a very early stage. The casts were not seen before the second day of the attack. They were red branching moulds of the bronchi, about two inches in their greatest length, having the consistence of soft jelly and preserving their form when removed into a bowl of water. To all appearance they were extensions downwards into the next bronchial subdivisions, of the clot which had formed against a rupture in a vessel in the bronchial lining. The peculiar shape and extent of the clot seemed best explained by supposing that the point of vascular rupture was at or near the angle of subdivision of a bronchus, where close and immediate apposition of a clot would not be so easily obtained as it would be midway along a bronchus. In my patient, a young lady of twenty-three, the temperature rose from normal to 102° on the second day of the bleeding, and it continued high not only throughout the week of bleeding, but for three weeks more. Since then it has followed a minor hectic range. Dr. Ord has seen the temperature rise from bronchial plugging, and the late Dr. Wilson Fox said that in plastic bronchitis there may be pyrexia in the early stages. The presence of the moulded clot in the bronchi may explain why my patient's temperature rose so abruptly during the hæmorrhage; and the subsequent time that it remained high perhaps covered the period required for the disintegration and removal of the final clot. The case was notable for the great mobility of the

vaso-motor system, the face flushing and blanching on the least emotion. The blood-supply of the body was not deficient, but the arteries were small and tension low, suggesting that the ruptured vessel was more probably a vein than an artery. The heart was normal. The sputa now contain a few tubercle bacilli. On the maternal side an uncle died of hæmoptysis, and on the father's side there had been phthisis in the family.

A closing word as to treatment. It is clear that when these branching clots exist, cough is far more likely to be set up than in cases in which the clot is small and simple. A more extensive bronchial surface is submitted to irritation. This carries with it a greater liability to the displacement of the stanching clot and the re-establishment of the bleeding. Rest of the parts is essential. Here, then, is surely an indication for treatment of this variety of hæmoptysis. Ergot, which was freely tried, failed; no doubt because it did not fulfil this primary indication. With Dr. Ord's concurrence opium was given instead and as a sedative. Half-grain doses were taken every few hours at first and afterwards at longer intervals as safety seemed assured. The bleeding never returned after the opium was begun. Saline aperients were carefully given, and subsequently bromide of ammonium was prescribed to allay nervous irritability, with digitalis to restore a better balance between the arterial and venous systems. The patient is going on well.

#### SOLAR CAUTERY.

In the *Pacific Medical Journal*, July, is an interesting article upon this theme

by Dr. O. V. Thayer, of San Francisco. He is as enthusiastic as in former years (as noted in previous issues of our JOURNAL) over the possibility of using the sun's rays in destroying vascular growths on the skin, chancres, epitheliomas, etc. Unhappily for us his experience in the Eastern States was very discouraging, as sunny days were few. (This could not have been in Baltimore.) A number of interesting cases are related. The process of treatment is not set forth as fully as in an article from which we quoted some time ago.

#### PHOTOTHERAPEUTICS.

Antonino Sciascia, M. D., read at the Thirteenth Italian Ophthalmological Congress the following. (See, however, Dr. Thayer's article in the *Pacific Medical Journal*, quoted on this page.)

I have the honor for the first time to present in surgery a new medication—*phototherapeutics*. The biconvex lens of the ophthalmoscope may well answer the purpose of the phototherapeutic lens. This subjected to the action of light, and best of all, to the action of solar light, when the rays are concentrated at the proper distance, they may be transmitted in such a way as to produce any required degree of heat (from a slight amount to that of fire itself). Such thermogrades applied upon organic tissues will produce local excitements proportional to the degree of the exciting cause, *i. e.*, from a slight excitement to cauterization itself, so that they may be employed, according to the nature of the case, upon local circulation, upon cellular activity, upon a fungous growth to destroy the vitality of its pathogenous microbes; also to cauterize the neoplasms,



the solution of continuity, or to remove passive, torpid and indolent processes.

I have been able to study the photocaution in the cure of trachoma, contrasting it with chemical caustics, with electrical appliances, electrolysis and the galvano caustics; also with the thermocautery, in its effect upon the gonococcus and with the "jequiriti." It is hardly necessary to observe that with these latter means, even though in skillful hands there often will happen inconvenient burns which diffuse themselves in tissues which require the gentlest treatment and cause the operator to repent of his rashness.

The photocaution is the best of all these appliances, presenting by its simplicity all the advantages of the usual remedies without their inconveniences.

All this can be said with regard to the thermic side of the subject. With regard to the chemical aspect it may be added also that the solar light has a microbicidal and specific power to kill the bacilli of the malignant pustule of erysipelas and of typhus. Having regard, then, to the above it is now believed to be high time to apply the photocaution in the cure of such diseases. Erysipelas treated with my photocaution is readily cured without having recourse to the encircling method.

In conclusion, the photocaution discloses a new era for the cure of many diseases, especially infective; and by this means we have also the antiseptic effect of heat and the chemical antiseptic power of light, which, united in a single instrument, contribute a most interesting application of therapeutics. — *Pacific Medical Journal*, July.

#### CHILDBIRTH MORTALITY IN ENGLAND AND WALES.

Summing up his criticisms of extensive mortality statistics, Dr. Boxall, of London, reaches the following surprising conclusions:

It appears that the death-rate from childbirth has not been appreciably diminished so far as England and Wales are concerned and that as regards puerperal fever an actual increase has taken place in the provinces. Much has already been done towards the reduction of mortality from accidents of childbirth, especially in London, where immediate attendance is always available and further aid can be readily secured; but such results as have been obtained in lying-in hospitals and maternities by the adoption of antiseptic measures in the elimination of septic processes are not as yet apparent in obstetric practice generally throughout the country. The natural inference is that no approach towards the general adoption of antiseptic measures has yet been made. That this state of things exists is, on consideration, not a matter for surprise. For but a small proportion of obstetric practice is at present in the hands of those who have been educated in the use of antiseptics, and even of those who make a practice of following out aseptic and antiseptic principles but few do so in a really efficient manner. The reduction of puerperal mortality on any considerable scale is as yet a dream of the future, and it must take years before that dream is fully realized. Already encouraging signs are apparent, in so far that the rise in the death-rate from puerperal fever which has taken place during the last decade in the provinces has not attained to cor-

responding proportions in London. In London and the larger towns, where antiseptic measures are naturally more freely adopted, improvement may be first looked for, and that the provinces will shortly follow suit may be confidently anticipated.

#### PAPAIN FOR LUPUS VULGARIS.

The following is selected from a report given in the *Lancet* by Dr. Francis, of Queensland:

Six months ago I was consulted by a man suffering from lupus vulgaris. He had a patch about the size of a two-shilling piece on the left cheek, extending from the ala of the nose. From the history of the case and its appearance I felt there could be no doubt as to the diagnosis, but in order to make the test more reliable I had the diagnosis confirmed by the opinion of two other medical men. I gave the patient a saturated solution of papain in glycerine, with instructions that a small quantity was to be rubbed in over the patch night and morning. The patient did not carry out my instructions regularly; but in two months there was a great improvement in its appearance. The papules had disappeared, and although the surface was still raw and red it had a healthier appearance and showed marked signs of general healing. At the present time the ulceration has completely healed, the surface being soft and flexible and only slightly discolored. Mr. Lightoller has quoted a case to me of lupus vulgaris which on two occasions he had extensively scraped and cauterized. As the ulceration recurred, he employed papain, under which the disease apparently disappeared, and after a lapse of three years there has been no return.

I know that single cases prove little or nothing; but these, I consider, warrant a further trial being given to papain, the usefulness of which may possibly be greatly extended.

#### THE MEDICAL LAW OF PENNSYLVANIA.

The following extract, from the report of the Committee on Legislation of the State Medical Society, presents in brief the terms of the new Pennsylvania law:

From March 1st, 1894, the Medical Council of Pennsylvania shall have control of the examination and licensing of all physicians intending to enter upon practice in the State.

The Medical Council shall decide as to the competency of the preliminary education of intending practitioners and as to their moral character; and must require them to have a medical diploma conferring the full right to practice all the branches of medicine and surgery. Diplomas granted to such applicants after July 1st, 1895, must have been obtained after four years medical study, three of which years must have been in college.

When these facts have been satisfactorily proved by affidavit, the applicant for license pays a fee of twenty-five dollars and is referred for examination to one of the three State Boards of Medical Examiners, which substantially act as committees under the supervision of the Medical Council.

The three State Boards of Medical Examiners are appointed by the Governor from the members respectively of the Medical Society of the State of Pennsylvania, the Homœopathic State Medical Society and the Eclectic State Medical

Society; and consist each of seven members.

The applicant makes a choice of the Board by which he wishes to be examined; but the questions must be the same before the three Boards in all branches except materia medica, therapeutics and practice of medicine. The Medical Council, moreover, selects the questions for all examinations from lists of questions submitted to it by the three Boards of Examiners. The examinations must be in writing and the questions, answers and marks preserved for reference.

The Medical Council, having received notice that an applicant has passed a successful examination, issues its license, with the seal of the Commonwealth attached, to the candidate, if he be adjudged by the Council to be duly qualified to practise medicine and surgery.

The Council fixes the standard of qualifications, and has a veto on all rules and regulations adopted by the three Boards of Examiners. It may issue licenses without examination to physicians licensed by Medical Examining Board or Boards of Health of other States.

The Medical Council consists of the President of the State Board of Health and Vital Statistics, representing the medical branch of the State Government, the Attorney General, representing the legal department of the Government, the Superintendent of Public Instruction, representing the Educational department, and the Lieutenant Governor and the Secretary of Internal Affairs, representing the Legislative and Executive departments, and finally the Presidents of the three State Boards of Medical Examiners.

By the provisions of this law, no one

can enter upon the practice of medicine in this State after March 1st, 1894, unless he or she has a competent common school education, has received a medical diploma, and has been granted a license to practice medicine and surgery by the Medical Council of Pennsylvania, after an examination by a State Board of Medical Examiners.

Applicants for license, who have received their medical degrees after July 1st, 1894, are not eligible for examination and license, unless they have attended three courses of medical lectures, in three different years; and those who have received their medical degrees after July 1st, 1895, are not admitted to examination for license unless they have studied medicine for a period of four years, three of which must have been in college.

#### ADHESION OF POSTERIOR VAGINAL WALL TO ANTERIOR PART OF CERVIX.

The following was reported by Dr. Springle in the *Montreal Medical Journal*, June:

Mrs. M., aged 27, Irish, had always enjoyed fair health to date of marriage, four years ago. She was delivered of a large child after a long, tedious labor, with instrumental aid.

Since that time she has aborted twice at the third month, suffering greatly before each mishap with pelvic distress and pain. In the intervals she did not complain either of pain or disordered menstruation.

In December, 1891, I attended her for her third abortion, which was complete when first seen. On vaginal examination, the following peculiar condition was found to exist:—

The posterior vaginal wall was raised,



by a tough fibrous cord, in a tent-like manner to the anterior lip of the cervix in front of the os, leaving an aperture on either side, through which the finger could explore the parts beyond. The adhesion measured about one-eighth of an inch in diameter at its attachment to the cervix. At the time, the uterus appeared to be held down by this band.

The patient made a good recovery, and the adhesion was subsequently divided. Adhesion in this case probably was the result of her first confinement.

Whether the condition was responsible for the repeated abortions, I am unable to say positively, as she has not become pregnant since.

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### Medical Items.

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Dr. Nicholas Senn, of Chicago, has been appointed Surgeon-General of the State of Illinois.

Dr. Wm. E. Mosely, of our city, is spending his vacation this year at Fairhaven, Mass.

After several weeks vacation at Adamsville, R. I., Dr. Wm. Whitridge has returned to the city much benefited by his trip.

“One ob de penalties ob greatness,” said Uncle Eben, “is ter be specially conspicuous ebry time yer makes er fool ob yerself.”—*Washington Star*.

Dr. Wm. T. Howard, Senior, Professor in the University of Maryland, was married July 17th, in St. Paul's Episcopal Church, to Miss Williams, of this city.

The sheriff has closed the Keeley Institute at Chicago. The director charges the failure to the inability of the institute to exert the same control over the Chicago saloons that Keeley does over those of Dwight.—*Cin. Lancet-Clinic*.

The Section on Pediatrics of the New York Academy of Medicine recently decided to appoint a committee to formulate rules suggestive to farmers and dairy-men of the best manner for caring for milk intended for the city market.

We note with pleasure that our friend, Dr. J. W. Long, of Randleman, North Carolina, has been elected to the chair of Diseases of Women and Children in the Medical College of Virginia, located in Richmond. Dr. Long's recent contributions to the columns of this JOURNAL were read with unusual interest.

We have received an ingenious “Chest Diagnosis Chart” from the inventor, Dr. Charles Denison, A. M., M. D., Professor of Diseases of the Chest and of Climatology in the University of Denver. It is for sale by Charles Truax, Greene & Co., Chicago. The price is \$1.00 for 100 copies of the chart.

At the last meeting of the Ohio State Medical Society, the following officers were elected: President, N. P. Dandridge, M. D., of Cincinnati; Vice-Presidents, F. C. Larimore, M. D., Mt. Vernon; Wm. Caldwell, M. D., Fremont; W. P. Corlett, M. D., Cleveland; L. S. McCurdy, M. D., Dennison. Secretary, Thos. Hubbard, M. D., Toledo; Assistant Secretary, Chas. Graefe, M. D., Sandusky; Treasurer, J. A. Duncan, M. D., Toledo.

In view of the approaching adoption of the metrical system by pharmacists in America the following from a contemporary is interesting: The French papers give an account of a serious error committed by a pharmacist in the Cotes-du-Nord in dispensing the following prescription: Antipyrin, 2 grammes; aconitin, 6 milligrammes. He mistook a six-centigramme weight for a six-milligramme one and thus dispensed ten time the intended dose of aconitin. He did not discover his blunder until an hour afterwards; he then hastened to the patient's house, and, finding that he had just taken the medicine, promptly administered an emetic, but unfortunately did not succeed in saving his life.

The *Sun* furnishes us with this striking illustration of the unlimited push of the nineteenth century human. We strongly suspect that a cold wave will strike some of the investors before long; but time will tell. The report is that an association called the International Cold Wave Company of Aberdeen, South Dakota, with a capital of \$2,000,000 and a surplus one-third that sum, has been organized by local capitalists and enthusiasts, who expect to make untold wealth in the next few years.

The company alleges that it has discovered a secret the potency of which, if applied at the right time and under favorable conditions, will vitiate and destroy the hot winds which arise in Kansas and at times have been known to sweep this country, burning and killing the growing crops.

This secret will be placed on sale and revealed to residents of townships, counties and other political divisions who put up the money.

Just what process has been evolved or to whom the marvelous discovery is to be attributed are not matters for publicity.

What the United States really needs is protection, not from the Chinaman, but from the unwillingness to do humble labor himself and from the insane delusion that a high school or academic education is an open sesame to success in life. It is not the case by any means, neither is it necessary to have wealth in childhood to become a man of note. Franklin, Patrick Henry and the many notable men of the past, as well as the Lincolns, the Douglasses, Websters, Greeleys or Garfields of the present age, are evidences of what it takes to make the man. The following was the occupation of the fathers of men who have made their mark. Literature as well as the fine arts are here well represented:

The father of Samuel Pepys was a tailor. The father of James Mill was a cobbler. The father of Verne was a day laborer. The father of Oliver Cromwell was a brewer. Epictetus was the son of a day laborer. Socrates was the son of a day laborer. Giotto, the artist, was a peasant's son. Talma, the actor, was a dentist's son. The father of Pius V was a shepherd. Schumann's father was a bookseller. The father of Pius IV was a peasant. The father of Cowley was a grocer. Charles Lamb was a servant's son. Mozart's father was a bookbinder. Milton was the son of a copyist. Pope's father was a merchant. Neander's father was a carter. Lucian was a sculptor's son. Homer was a farmer's son.—Dr. P. C. Remondino in the *National Popular Review*.

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### Original Articles.

#### A CASE OF PROBABLE MENINGEAL HÆMORRHAGE WITH SYMPTOMS RESEMBLING GENERAL PARESIS.\*

BY GEORGE J. PRESTON, M. D.,  
OF BALTIMORE.

When we consider how abundant the blood supply of the brain is, and how slight is the support afforded the vessels by the soft tissue in which they are embedded or upon which they lie, it is not surprising that we often see cases of rupture of the vessels produced by external violence which is not sufficient to cause fracture of the skull. Cases of this kind are often very puzzling from the lack of

localizing symptoms. Nor is it always easy to decide whether we are dealing with a case of diffuse hæmorrhage or one of laceration. The symptoms whether convulsive or paralytic, dependent upon injury done to the motor region of the cortex of the brain, are usually plain enough. Certain of the sensory cortical centers are sufficiently well known for localizing value, vision especially. The language center gives us another landmark for the left hemisphere. A large part of the occipital, parietal, and frontal cortical regions afford few symptoms of localizing value when injured.

The inferences to be drawn from the case to be related cannot of course be regarded as anything more than probable, since the patient has partially recovered. The case, however, was one of great in-

\* Read before the Medical and Surgical Society of Baltimore, March 23rd.



terest to me, since the symptoms pointed to injury done both motor and psychic areas. The case referred to is briefly as follows:

James Price, colored, aged 30, laborer, with good family and personal history, admitted to City Hospital July 14, 1892. On the night of the 13th he was struck by a freight train and rendered unconscious, in which condition he was admitted into hospital. There was a very slight scalp wound and a few bruises in other parts of the body, but no external injury of any importance. The case was supposed to be merely one of concussion of the brain. There was no rise of temperature and at first no evidence of paralysis. Soon after admission the patient became delirious, talking in a wild, incoherent manner.

A careful examination made on July 16th showed that the patient had to a certain extent recovered consciousness but his mental condition was bad. There was partial paralysis of all four extremities with greatly increased reflexes and ankle clonus on both sides. No loss of sensation. Pupil reflexes normal and ophthalmoscopic examination revealed nothing abnormal.

After some days the patient got out of bed and upon attempting to walk he staggered and fell. He had a reeling, drunken gait and was not able to walk across the ward without support. There was a general tremor, intensified by any attempts at movement. His speech was thick and slurring, with a tendency to drop the ends of words. There was a slight fibrillary tremor of the muscles of the mouth when speaking, and also a spasmodic twitching of the right side of the face.

Gradually, that is during the first weeks, the patient developed a well marked delirium of grandeur. He imagined that he had plenty of money; told me that he had \$5,000, which it is needless to say was entirely a delusion. The other patients in the ward were greatly amused at his extravagances. His memory was very defective and the accounts he gave of himself utterly untrue. These symptoms continued without any very marked change for nearly two months, and then a gradual improvement set in. His grandiose delusions slowly disappeared, his memory became clearer and the expression of his face, which had been very silly and self complacent, became more natural. The paralysis improved to such a degree that he was able to hobble across the ward with the aid of two canes. The muscular weakness continued great and the reflexes were still exaggerated; there was no muscular atrophy at any time. The patient left the Hospital about the middle of November.

The symptoms bore a striking resemblance to general paresis: the general paralysis involving as it did all four extremities and also the muscles of articulation, the tremor, altered reflexes, thick speech, muscular twitchings, loss of memory, and expansive delusions. Patient's friends reported that he was perfectly sound mentally and physically just prior to the accident. But for this fact and also for the fact that the symptoms gradually improved and the delusions disappeared I should have been inclined to regard the case as one of general paresis in which the symptoms had been merely intensified and hurried up by the shock. The

motor symptoms, paralysis, tremor, spasmodic movements, involving as they did all four extremities, point to a widespread, but slight lesion. The psychic symptoms, loss of memory and delusions point to the probable involvement of the frontal area. In all probability the frontal and Rolandic regions were involved to a degree sufficient to produce a partial but not complete loss of function. The symptoms indicate that the injury was to the cortex and of such a nature that the tissues gradually recovered, to some degree, their normal condition. The sudden onset of the symptoms, following an injury, points unmistakably to hæmorrhage, as does the gradual improvement due to absorption. The hæmorrhage must have been widespread to involve the motor and probably the frontal regions of both hemispheres.

The absence of fever almost precludes the possibility of meningitis. The most natural explanation of the condition is that as a result of the blow to the skull hæmorrhage occurred which covered the under surface of the dura-mater with a thin layer of blood, resembling what is known as pachymeningitis hemorrhagica interna.

The above case is interesting on account of the widespread symptoms following a traumatism and the close resemblance which these symptoms bear to those of general paresis. If, however, we keep in mind the pathology of general paresis, the explanation given of the probable nature of the case related above—namely, that the cortex was involved to a wide extent, but a slight degree only—becomes highly probable. Another conclusion which may I think be drawn from the case is the neces-

sity of opening the skull in all cases in which, following injury, unconsciousness is long continued, regardless of other symptoms, and regardless of the apparent trivial nature of the head injury.

819 N. Charles Street.

## INDIVIDUAL EXPERIENCE IN THE TREATMENT OF VESICAL CALCULUS.\*

BY JOHN ASHHURST, JR., M. D.

I find in looking over my records that I have removed calculi from the body in fifty-one cases. One case was that of a female child, one on whom I performed lithectomy, or rapid dilatation of the urethra, but the remaining fifty were in male subjects. In thirty-five of these fifty cases the patients were operated on by lateral lithotomy, which is the cutting operation that I prefer. I recognize that there are cases in which the median operation is to be preferred, and that there are other cases in which the supra-pubic operation is the best, but where the surgeon has the choice of operation, I think that he should select lateral lithotomy. Of the thirty-five cases operated on by the lateral method, twenty were in children under the age of puberty, and in every case the patient recovered. In males beyond the age of puberty, including a fair proportion of quite old persons, I have had fifteen cases with three deaths, but only one of these three was really the result of the operation. That occurred in a case operated on in a neighboring town this winter. Secondary hæmorrhage occurred on the ninth or tenth day, and the at-

\*Read before the Philadelphia Academy of Surgery,

tempts made by the attending physician to control it were not successful.

I have six cases of the median operation, with one death, to report. In one case the operation was done for the removal of a foreign body, the end of a catheter. In this case I succeeded not only in removing the foreign body, on which there was a small calcareous deposit, but also in relieving the chronic retention of urine, from which the patient had long suffered, by tearing off the median lobe of the prostate with the forceps. This was fully ten years ago; the patient is still living, and I believe has not had occasion to use a catheter since. The case which proved fatal was in a patient in the last stages of cystitis and chronic renal disease, and in which the presence of the stone was simply a complication. An interesting feature in this case was that, in addition to the presence of a stone, there was a large quantity of that semi-organized material which has been described by Vandyke Carter as the animal basis of calculi.

I have one case of the supra-pubic operation, in which the stone was a small one, this particular operation being chosen because the case was really one of villous tumor of the bladder, and the presence of the stone was simply a complication. The patient was in a critical condition from hæmorrhage at the time of the operation, but made a good recovery.

I have no case of the old-fashioned lithotrity. The operation had already come to be rarely practised before I had occasion to resort to the crushing method. The early portion of my practice was largely with children, and Bigelow's

modification had already become the operation of preference when I first felt I had a case adapted to its performance. I have performed this operation eight times, with six satisfactory recoveries and two deaths. Both the deaths were from uræmia, dependent upon chronic disease of the kidney.

I have brought here a number of the calculi which I have removed. The largest weighs three ounces and some drachms. It was removed by the ordinary lateral operation. It was not necessary to enlarge the wound by dividing the right side of the prostate, nor was it necessary to crush the stone. By making a large external wound, by grasping the stone with sufficiently powerful forceps, and by patience in manipulation, this stone was removed without difficulty, and the patient made an excellent convalescence.

The largest number of stones which I have removed from one patient is fifty-four. These were removed by lateral lithotomy. The patient made a good recovery, but returned in a year or so with recurrence of the symptoms from a descent of more stones from the kidney. On that occasion I determined to perform the operation of litholapaxy. The patient did pretty well for a few days, but then the urine became turbid, containing a large quantity of ropy mucus and pus, uræmia developed, and the patient died in convulsions. This was a forcible illustration of the risk attending litholapaxy in cases of cystitis, and since the occurrence of that case I make it a rule, where the patient presents cystitis in an advanced degree, to recommend the cutting rather than the crushing operation.

With regard to the results that I have



reached from my own experience, I would say, in the first place, that I have never seen any reason to wish for a better operation than lateral lithotomy in children. Litholapaxy has been resorted to successfully a number of times, and with the improved instruments which we now have the operation is a feasible one, while it could hardly be considered such a few years ago. Until within a short time it has not been possible to get instruments of sufficient strength and delicacy for use in the urethræ and bladders of children. Even now, the operation of litholapaxy in children seems to me to be a more severe one than lithotomy. The results of cutting for stone in children are so satisfactory that I think we want nothing better. The great advantage of litholapaxy it seems to me is the short time required for after-treatment. If all goes well, litholapaxy will allow the patient to go about his business in five or six days. This is a great advantage in adults who are engaged in active business; but in young children it is a matter of no importance. At the same time I am willing to admit that the operation has been improved to such an extent that it is one which may be legitimately resorted to in children if the surgeon thinks that it is preferable.

The median operation seems to have a very limited field. Cases of foreign body in the bladder, and cases of very small stone, are those to which this operation is adapted. In some of my cases the operation was not begun with the knowledge that a stone was present, but for retention of urine where it was not possible to pass an instrument by the urethra. The argument which has been advanced in favor of this operation, that

it is attended with less risk of hæmorrhage, does not seem to be entirely well founded. There is very little more risk in the lateral operation. The transverse perineal artery is divided, but with a little care it is not likely that the internal pudic or the artery of the bulb will be injured. In the old days of operation without an anæsthetic, it was quite possible that one of these arteries might be wounded in the struggles of the patient. The artery of the bulb can be avoided by striking the staff as far back as possible. The hæmorrhage from which I have had trouble has been from the prostatic plexus of veins, and this is quite as likely to occur in the median as in the lateral operation, and, indeed, I have seen very profuse hæmorrhage from this source after median section.

The supra-pubic operation, although just at present the fashionable method, I should reserve for very large stones, or for cases in which there was some complication, such as tumor, in addition to the stone. Cases of vesical tumor are satisfactorily dealt with through the supra-pubic incision, but where the case is an uncomplicated one of stone, I have not seen any reason to prefer this to the lateral method.

In the female, the operation of lithectomy or rapid dilatation is the one to be chosen, and in almost all cases will be sufficient. Mr. Bryant has shown that stones of considerable size can be removed by this method. In children, stones up to half an inch in diameter, and in adults stones up to one inch in diameter, can be thus removed. If the stone is larger, it can be broken into several fragments before removal. I believe that the results of this method

will be more satisfactory than if an attempt is made to remove the calculus by litholapaxy or by any form of lithotomy. The vesico-vaginal section may leave a permanent fistula. The high operation may, of course, be required for very large stones.

As regards the operation of lateral lithotomy, the points which are to be observed are, in the first place, to make a large external wound. I have seen very serious trouble result from too small an external incision. There is no objection to a large wound through the skin and superficial fascia; if hæmorrhage occurs, it is easier to deal with it through a large wound, and drainage is more satisfactorily effected. In the second place, I think that it is of great importance to strike the staff as far back as possible. Instead of striking it where it is most superficial, I endeavor to get as far back toward the horizontal portion of the staff as possible. In that way you avoid wounding the artery of the bulb, and obtain plenty of room where it is needed. My preference is to have the staff firmly hooked up under the pubis, instead of having it made to project in the perineum. I believe that in this way it is more firmly held, and that the surgeon can fix the position of the anatomical points better, and therefore cut with more precision. Having struck the staff, I think, following the advice of Sir William Fergusson, that the deep incision should be made small. I believe that there is a decided advantage in this plan. I do not say that the surgeon should not make the wound in some degree proportionate to the size of the calculus, and in cases where there is a large stone, I am in the habit, as I withdraw

the knife, of bringing it slightly away from the staff so as to enlarge the deep wound. In children the knife should be withdrawn in close contact with the staff; but in the adult I drop the knife a little, so as to enlarge the wound in the prostate. The finger is then introduced, and the prostatic enlargement completed by dilatation. I do not at all agree with the view of Mr. Teevan, that it is safer to cut the prostate than to stretch it. In the introduction of the finger I lay stress on its introduction above the curve of the staff. In children this is very important, for if it is not done, the finger may not enter the bladder, but may pass into the recto-vesical space. The surgeon cannot miss the bladder if he passes the finger above the staff, as it is well held up under the pubis.

In my earlier operations I had a great fancy for the scoop in removing calculi, using it as the obstetrician uses the vectis getting the scoop behind the stone and the finger in front of it, and bringing all out together. Of late years I have used the forceps more and the scoop less, although at times it answers a useful purpose. In the withdrawal of the stone, a mistake that I have often seen made is not carrying the forceps far enough backward toward the coccyx. The portion of the wound where there is plenty of room is far back. I have seen surgeons try unsuccessfully to remove the stone through the anterior portion of the wound, when it could have been readily removed if the forceps had been dropped toward the back.

In the high operation, it is a great advantage to have the bladder and the rectum distended, though, perhaps, not absolutely necessary. There is an ad-

vantage, too, in lateral lithotomy, in having a moderate quantity of fluid, say about four ounces, in the bladder before the operation, as the gush of water, when the bladder is opened, will bring the stone down on the end of the finger. If, however, the bladder is intolerant, I do not care to have it much distended.

With regard to the operation of litholapaxy, the points which I consider to be of importance are, in the first place, to crush the stone as thoroughly as can be done, and then, when using the evacuator, to make the stream enter with great gentleness. I believe that cystitis may be aggravated or even caused by using too much force. As regards the rapidity of the operation of litholapaxy. I have no doubt that an operator will do it with greater rapidity as he does it of tence, but for my own part, I have found it a slow operation. I think that no surgeon should undertake it who is not prepared to give as many hours to it as may be necessary. I can recall three cases in the practice of other surgeons in which the patients died as the direct result of having a stone left half crushed in the bladder. Violent cystitis came on and the patients succumbed. Where the operation is undertaken, it should be completed. If the surgeon is not prepared to remove the entire stone at one sitting, he should not undertake the operation at all. This is the operation for small stones in patients with healthy bladders. Cystitis is the most dangerous condition in which to resort to litholapaxy. In the case of an adult presenting himself with stone, my first thought is of litholapaxy. I then consider the various circumstances in the case. Litholapaxy has so many advan-

tages in cases in which it is adapted, that I think it should be the surgeon's first choice.

With regard to the objection that lateral lithotomy may render the patient sterile, I do not see why that should be, provided that the operation is confined to one side of the perineum, and that no undue amount of inflammation follows. If there were a great deal of inflammation, it is quite possible that there might be such obstruction of the vas deferens as to prevent the patient from generating with the testis of that side, but there is no more reason why the patient should be rendered sterile by the operation of lateral lithotomy than by the removal of one testicle. In the immense number of operations performed in former years, we never heard of this objection, and I believe that it is rather theoretical than practical.

I have had one case of stone weighing less than two grains, which I diagnosed by the sound, and removed by lateral lithotomy. The patient was a lad who had the symptoms of stone in the bladder, and in addition, frequent attacks of sudden and complete retention of urine, due to the calculus entering and plugging the internal meatus. The straining was so excessive that, in the effort to pass water the night before the operation, the patient ruptured sub-conjunctival vessels in both eyes.

I wish to refer to a few cases of cystotomy for other causes than calculus. I do not include cases where I have operated by Sir Henry Thompson's method of puncturing a contracted bladder above the pubis. I find that I have opened the bladder by cystotomy in eight cases, six of these being cases of cystitis.



Of these six, four recovered, and two died, as the result of the diseased state of the urinary organs. In two instances I have opened the bladder for intense pain in the act of micturition, due to a fissure at the neck of the organ. Both patients recovered. In one case the fissure followed cystitis, the result of gonorrhœa, and in the other case, the symptoms came on after the use of very large sounds.

I have had one case of cystotomy in a child for tuberculous disease of the bladder. This case was one of a good deal of interest. The patient had, at one time, been under the care of the late Professor S. D. Gross, who had sounded the child, and said that he felt a stone. It is to be observed, however, that he never appointed a time to operate, so that it is possible that he may have had some doubts as to the diagnosis. A curious feature of the case was that the father, who was a man of considerable intelligence, declared that he had himself distinctly heard the click of the stone against the instrument. I sounded the child, but was not entirely satisfied that a calculus was present, although, from the history, I thought it probable. The child had all the usual symptoms of stone, except sudden arrest of the urine. I asked Dr. Forbes to see the case with me, and we thought it right to open the bladder. No stone was found, but there were discharged twenty or thirty little bodies which I presume were what the older surgeons would have spoken of as fibrinous calculi. They looked like little pieces of catgut. Whether these were masses of tuberculous material, or of inspissated mucus and lymph, I do not know. The patient was relieved of his

symptoms, but died two months afterward of tuberculous disease of the mesenteric glands.

#### CAUSATION OF EPILEPSY.

Victor Horsley reaches the following conclusions in summing up a recent address on the origin and seat of epileptic disturbance: "Whatever be the point which the epileptogenous agency first attacks, we must conclude that the principal seat of disturbance of a general or idiopathic fit must be the cerebral hemispheres, and especially their cortical mantle. Further, that the condition of the cortex during the attack is one of congestion and not anæmia; and finally, that in all probability this portion of encephalon is actually the place of origin of the disturbance."—*Ex.*

The Emperor of Austria has accepted the office of Protector of the International Congress of Hygiene and Demography, which will be held in Budapesth in 1894. The organizing and executive committees have now been formed and are in full work. The Congress will consist of two divisions, hygiene and demography. We are asked to remind our readers that the committees of each section have been appointed. The General Secretary is Dr. Koloman Müller.

In a letter from Dr. A. S. Kaufman, a graduate of the class of '93, Baltimore Medical College, we learn that he has entered into active practice at 905 Fifth Ave., New Kensington (a town in the Allegheny Valley 18 miles from Pittsburg) after passing the examinations at the Western Pa. Med. College necessary for endorsement of the Maryland diploma.

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BALTIMORE, JULY 29, 1893.

**Editorial.**

## PROPOSED ACADEMY OF MEDICINE IN BROOKLYN.

The munificent founder of the Hoagland Laboratory in Brooklyn, N. Y., has under consideration a project which, if carried out, will provide for that locality a home for rational medicine. At a conference lately held, the following were named a committee to consider all the needs of the profession and the best way of satisfying them, in respect of a meeting-place and library under one roof:

For the King's County Medical Association, Dr. E. R. Squibb; Brooklyn Gynecological Society, Dr. Chas. Jewett; Brooklyn Dermatological Society, Dr. J. M. Winfield; Brooklyn Pathological Society, Dr. E. H. Wilson; Brooklyn Surgical Society, Dr. H. B. Delatour; German Medical Society, Dr. J. H. Droge; Medical Society of the County of Kings, Dr. Z. T. Emery; Brooklyn So-

ciety for Neurology, Dr. T. M. Lloyd; Hospital Graduates' Club, Dr. F. W. Shaw; and the Long Island Medical Society, Dr. L. Coffin.

Dr. C. N. Hoagland has at least \$40,000 ready to put into the undertaking in the event that an unanimity is manifested by the various organizations. It is believed that if the societies interested can raise \$50,000 he will subscribe an equal amount. The committee named above will be expected to report soon as to the attitude of the various bodies intended to be benefited by the proposed Academia.

## TATTOOING IN THE ARMY.

Assistant Surgeon A. E. Bradley, U. S. A., writes to the *New York Medical Journal* that there has been by him observed very little of tattooing practised among enlisted men. It is true that many soldiers bear tattooed marks that were upon their bodies at the time of their enlistment; but it is a mistake, in his judgment, to assert as some have done that there is a great deal of it done after that time. Dr. Bradley criticizes those statements that allege that the soldiers mark themselves with designs of an obscene and indelicate nature and with lewd legends or mottoes. However it may be among soldiers of other nations, the writer claims that there is indeed but little tattooing of any kind to be found in the army. He recently had a tour of recruiting duty to perform at New York City, during which time he saw over two thousand recruits, and not one of them bore marks that could be classed as obscene or indecent.

The existing regulations touching on

enlistments are adverse to the admission into the army of men bearing on their persons indelible figures or designs of an unseemly description. Such men are virtually ineligible, and it is rare indeed that they can "slip through" into the service of the United States. A soldier of twenty-five years service in the army stated to the writer that he had never seen any indecent tattooing done upon an enlisted man in all that time, although he had known of several instances of that nature among sailors, during a six years service in the navy, before the war. And the amount of tattooing of any kind among soldiers is at present very limited.

### Reviews, Books and Pamphlets.

*A Hand-book of Local Therapeutics*; by Allen, Harte, Harlan and Van Harlingen. Edited by Harrison Allen, M.D. Octavo, 500 pages, price \$4.00. P. Blackiston, Son & Co., Philadelphia,

The need for a book of this character has long been apparent, for there has been no text available in which the *local action of drugs* was not subordinated to their general actions, while the average text-book omits altogether the mention of many agents that in the hands of a specialist become valuable aids to cure.

Diseases which require chiefly local treatment are those of the respiratory passages, eye, ear, and skin, together with certain general surgical affections, including diseases of women; it is therefore to the great advantage of the work that each remedy has been thoroughly set forth by different authors who have had large practical experience in these various branches.

Each remedy has been taken up in alphabetical order, and after a description of its pharmaceutical properties, is considered in reference to its physiological effect and value in local treatment.

The demands for thorough revision of local medicaments made by the advance of theories of asepsis have been fully considered, and a succinct account has been presented of the source and properties of the very numerous new agents which affect tissues locally.

Some drugs have been excluded which have been highly praised; on the other hand, great care has been taken not to indorse imperfectly attested novelties.

This Hand-book embodies the results obtained by experienced teachers, and will prove a very valuable work to the general practitioner. Two carefully made indexes make it a book of ready reference.

### Medical Progress.

#### RETROFLEXIO UTERI.

In closing a thoughtful article upon this subject (*Virginia Medical Monthly*, July), Dr. Buist draws the following conclusions:

1. We believe that in the large majority of cases the predominant morbid state allowing of retroflexion is to be found in the uterus itself; a diseased state of this organ is the primum mobile of the trouble.

2. Next, an extension of the metritic disease to the tubes, ovaries and peritoneum is the most usual sequence of changes, and the relaxation of ligamentous supports the last.

3. The skilled gynecologist will treat the complications first, resort to pessaries



ries last, and when opportunity offers, or the symptoms are severe enough, select some one of the surgical methods of fixation.

#### URINALYSIS BEFORE ENUCLEATION.

In response to interrogation of fifteen oculists in different parts of the United States concerning the extent to which they were influenced, in deciding to operate on the eye, by the condition of the urine, Dr. Magee, of Topeka, Kansas (*Kansas Medical Journal*, July), received reports which he summarizes as follows:

As to making an examination of urine: Six, never make a urinalysis; seven, only in cataract cases; two, only where they are suspicious.

They all recognized the unfavorable condition of the presence of sugar and albumen, yet but one would refuse to operate, and he only where it remained permanently in the urine.

Not one considered the presence of an excess of the earthy phosphates of sufficient importance to make any notice of it.

#### NOTES.

1. If the patient was willing to take his chances, all were willing to operate, no matter if albumen or sugar were present, and run the risk as to the results.

2. One thought that where the glycosuria was due to ocular disturbance, it could be relieved by the operation.

3. Two would first place their patients upon general treatment.

4. Three, give fair results in diabetic patients in extraction of cataract.

5. One went even so far as to say

he would operate, no matter how much sugar or albumen were present, if nothing more than temporary relief was obtained.

#### THE PAINS WHICH FOLLOW INFLUENZA.

In view of the prevalence of such pains in the community during the past two years, an extract from an able paper by Dr. W. R. Gowers, of London (*Lancet*, July 1st), on the Nervous Sequelæ of Influenza will be of interest. He says:

As I have just said, rheumatism is not uncommon as a sequel to influenza, and it is especially common at the present time, having, in many cases, succeeded a comparatively slight recurrence of the disease. The pains in the muscles of the back or about the muscles of the limbs continue, or those of the primary affection may cease and be renewed after an interval of a few days or at most of a few weeks. They spread in one or many regions, but often become fixed in some one district, and continue there as pain on movement, sometimes even pain at rest, with tenderness also on pressure. Nerves in the vicinity of the affected fibrous tissues may become distinctly tender, and spontaneous pain may follow their course, whilst that on movement is felt through a wider area.

These persistent rheumatic affections after influenza occur especially in those who inherit a predisposition to gout or so that form of rheumatism which is allied to gout and is so often a result of this disease in ancestors. They occur chiefly in persons who are in the later periods of life, of either sex; but these affections occur also independently of this cause. Most practitioners, and all whose work is in rural districts, must be

familiar with the great frequency of chronic fibrous rheumatism in the old, how often it anticipates the effect of age in disabling the laborer, in whose inheritance gout assuredly has no place. The constitutional state which gives rise to it seems to be the result of the circulation in the blood of imperfectly changed products of the metabolism of the tissues, increased by imperfect digestive change in the material which the blood conveys to the tissues. Such imperfection is probably the result of the degenerative changes with various organs which are concerned with the transformation of the substance ingested, and with the due changes in those which should be prepared for expulsion from the system; and the effect of the inadequacy of the organs is to overload the blood with chemical substances of a more or less toxic character, closely allied to those which are probably the active agents in causing many of the manifestations of gout. You have doubtless not failed to note the growing tendency to regard the retention of uric acid as only one element in gout. It seems to be the agent in causing arthritis and some other local processes but to be accompanied in the blood by other material, also the result of the imperfection in the constitutional chemistry, which is, perhaps, more potent in deranging the nervous system. If so, we can more readily understand that some elements in gout should be almost incidental to age; and that those who inherit the latter malady, who have led careful lives, indisposing the inherited diathesis to manifest itself in the common manner, should suffer severely from these additional influences

which age brings with it, and often then become the subjects of intense and acute forms of articular inflammation. Such a train of causes is to be traced in most of the subjects of the severe rheumatic sequelæ of influenza, which seems often to supply the pathogenic influence required to induce activity in the latent tendencies. These patients have not suffered until the acute disease added its special toxic influence to that which before was without manifest effect, and might have remained so; but under this potent reinforcement rheumatic affections may become, as I have said, extremely severe and attain in many cases such a degree and fixation that the sufferer's failing powers are in many cases quite inadequate to liberate the system from the toils in which it has become bound.

#### SOME SIGNS OF ADVANCE.

Says Dr. Cecil, in the *Amer. Pract. and News*, June 17th:

A striking feature of the mutability of times and minds is the rapid growing distrust of antiseptics. A new antiseptic idol is no sooner set up than it is thrown down and broken. The simplicity of the master operators is simply admirable. The only two agents that defy the attacks of time and the idol-breakers are soap and water. The sterilization of instruments, hands, dressings, etc., is so simple that no one should err. The germicidal agents that for years have been deemed indispensable now either play an insignificant role or are consigned to the limbo of not only useless but harmful trumpery. Our best lessons, truly, are learned through our mistakes.

Another and hardly less important lesson in the after management of surgical cases is the almost universal abandonment of the use of opiates. Very few cases are benefited by or really demand the hypodermic use of morphia that for a long time was so generally administered. Some of the reasons that condemn its use are prolongation of the nausea and vomiting from the anaesthetic, the delay of prompt reaction, the arrest of the secretions, and the masking of important symptoms as they may arise. Nature untrammelled is the best restorer. Quite a lengthy article might be written upon the abuse of opium, or the advantages of not using it in surgery.

#### THINGS WORTH REMEMBERING.

Syringes, whose canals are clogged so that a wire cannot be drawn through, are cleaned by holding them a moment over a flame; the foreign substance is thus quickly destroyed and driven off. If a wire has been rusted into the needle it should be dipped in oil before holding over the flame. To remove the rust from the interior of the canula, it is well to pass oil through the canula, then heating it, then rinse it out with alcohol.

When danger threatens from the use of chloroform or cocaine, use amyl-nitrate.

Oleum ricini is claimed to be an infallible remedy for warts, applied once a day for six weeks.

Half a dram of boric acid in an ounce of alcohol is excellent treatment for acne if applied five or six times daily.

Dr. E. M. Hale, of Chicago, makes the statement: "I have the records of eleven cases of scirrhus and incipient sarcoma

of the breast, cured by means of conium and hydrastis tincture, in alternation or combined. These cases are now living in this city."

One-half drachm doses of the fluid extract of viburnum prunifolium have cured many cases of the vomiting of pregnancy.

Bartholow gives a small dose of nitric acid, largely diluted, every two hours in failure of the voice from mucous laryngitis or fatigue.

A writer in the *Lancet* claims to have relieved cases of obstinate tympanitis instantly by placing the patient in the knee-chest position.

Dr. Sarah Post recommends that vaginal douches be not employed in the treatment of unmarried women, as they are likely to excite sexual orgasm.

Half a teaspoonful of the ammonium chloride in a goblet of water is said to restore a drunken man to his mind and physical powers.

For epistaxis Dr. Genevil, of Paris, after washing the nostrils with fresh water injects a syringe full of *fresh lemon juice* (citric acid will not act as well).

Violent Vomiting—Woodbury says that a Seidlitz powder divided in four parts, one every fifteen minutes, has better results in violent vomiting than anything he knows of.—*Mass. Med. Jour.*

#### CERVICAL POST-PARTUM HÆMORRHAGE.

Not long ago a case came to our notice in which a woman was having an enormous *post-partum* hæmorrhage. With the first gush of bright red arterial blood through the vagina, the medical attendant became quite rattled, and, of course, at once attacked the uterus, stuffing its cavity firmly with antiseptic gauze, and then



commenced to inject beef-extract up the rectum, that she might make blood for what she was losing. But, seeing that his patient was fast sinking, and that he was powerless to control the flow, a consultant was sent for. On his arrival, he at once removed all the uterine packing, caught the neck of the uterus and pulled it into the vagina, when there, by the aid of a candle, he saw an enormous laceration up its inner wall, which tore the left uterine artery in two. In an instant the bleeding vessel was in the safe grip of a hæmostatic-forceps; a life had been saved.—*Times and Register*.

#### SQUINT IN CHILDREN.

The editor of the *Kansas Med. Jour.* says:

Squint in children should be corrected early in life. If let go for a number of years there is apt to be functional impairment of the retina, due to imperfect visual impressions conveyed to the nerve centers. An error of refraction may be the cause of imperfect retinal images. Correct the error and the development of the retina continues and the squint is corrected.

We have fitted glasses to children three years old. True, it is not so satisfactory as when they are older, and there is liability of breakage and injury to the eyes by broken glass and frames, but so far this has not happened in our practice.

If glasses fitted under atropine fail to correct the squint after a few months' trial, or the error of refraction cannot be corrected, an operation should be done if the squint is unsightly.

In case of lack of development and where the lenses improve the vision, we

may promise marked improvement eventually where full correction is made.

#### THE PULSE IN LARYNGEAL STENOSIS.

In a letter to the *British Medical Journal*, Dr. Battams calls attention to an important phenomenon occurring in children. He says:

I was astonished on reading Dr. Brockbank's interesting and able article on the above subject to find that a symptom so common in the laryngeal stenosis of children was not mentioned in our standard English works. During the many years I was resident medical officer to the East London Hospital for Children it was my very frequent and difficult task to decide on the necessity or otherwise of tracheotomy in cases admitted with laryngeal obstruction. During that time we had considerably over 100 cases of tracheotomy, so that my experience in this connection is rather large.

I look upon any marked and progressive diminution in the volume of the pulse, and especially its complete intermission during inspiration, as one of the most important of a group of symptoms indicating the necessity for tracheotomy. I find that this symptom is noted in the large majority of cases on which I have operated.

It occurs in cases which recover without operation, and, as far as my experience goes, this condition of the pulse has no great diagnostic value. As a rule, no doubt the extent to which the pulse disappears during inspiration varies directly with the amount of obstruction to the entrance of air. And, as cases in which the obstruction is most pronounced and sudden are said to be rather favorable for operation, the

pulsus paradoxus may have some prognostic value.

Whether pulsus paradoxus is the most convenient and appropriate term to apply to this condition of pulse, and whether Dr. Brockbank's scientific explanation as to the cause of its production is correct, I must leave others to say. To me this symptom has merely indicated an embarrassed heart, and I always thought that the chief difficulty lay in the right side. I find that in three cases I have noted that "the heart stops during inspiration." At this distance of time I cannot say precisely what I meant by this.

#### INDIRECT PURGING OF INFANTS.

A writer in the *Therapeutic Gazette* reports the following interesting observations on the purgation of sucklings by drugs administered to the mother:

1. *Senna*.—Eleven observations. In eight cases the compound licorice powder was administered and in three the confection of senna. The licorice powder was given in teaspoonful doses, for the most part once a day, but occasionally oftener. In one drachm of the powder there are ten grains of senna and five grains of sublimed sulphur.

In no case was the child purged by the use of the drug, which, in the majority of cases, was given in sufficient quantity to bring about a daily action of the mother's bowels.

2. *Aloes*.—Ten observations. In all cases the pill of Barbadoes aloes, combined with a quarter of a grain of extract of nux vomica, was administered. In five cases this pill was given twice a day and in five only once a day. The amount of Barbadoes aloes contained in each pill is 2.18 grains. In eight cases the chil-

dren's bowels were unaffected. In one case the child's bowels, which had previously acted every day, became somewhat more costive, and in one case the child's bowels acted more freely (twice a day instead of once a day). In this latter case it will be observed that the pill was taken twice a day.

3. *Cascara Sagrada*.—Ten observations. In seven cases the liquid extract was administered, and in three the solid extract. The liquid extract was given in  $\frac{1}{2}$ -drachm doses, combined with carminatives, three times a day. The solid extract was given in 2- to 5-grain doses twice a day. In eight cases the children's bowels were unaffected. In one case the child became more costive, and in one case less costive than before.

4. *Sulphate of Magnesium*.—Eleven observations. In all cases 1-drachm doses of sulphate of magnesium were administered three times a day. In five cases the children's bowels were unaffected. In five cases the bowels were more freely open than before. In one case the child's bowels became more costive.

#### HAINES' TEST FOR SUGAR.

On the whole the most excellent form of the copper test for sugar qualitatively is that devised by Prof. Walter Haines, of Chicago. The preparation of this test is simple in the extreme, as follows: 30 grains of sulphate of copper are dissolved in half an ounce of distilled water, to which half an ounce of glycerine is added, and the whole is then mixed with 5 ounces of liquor potassæ. In testing with this solution a drachm is gently boiled and the urine added drop by drop until 6 or 8 drops are added, *but not more*. If sugar be present, a co-

pious yellow or yellowish red precipitate is thrown down, consisting of the usual anhydrous suboxide of copper.

The advantages of Prof. Haines' test for qualitative purposes over other forms of the copper test are: 1. It is entirely stable, which enables it to be kept on hand indefinitely. 2. It is simple in construction, its components being at hand in all ordinary drug stores. 3. The relatively small quantity of urine employed in testing—3 to 8 drops—renders it least likely to mislead one through reducing agents in the urine, other than sugar. 4. Its delicacy is at least equal to that of any other form of the copper test.

With regard to the copper tests in general, it is important to bear in mind that boiling should not be too long continued, otherwise slight reduction is liable to occur with urine when free from sugar; about half a minute should constitute the usual limit of time. Lastly, it should be remembered that strongly alkaline solutions are apt to precipitate from the urine the earthy phosphates of calcium and magnesium in the form of a grayish cloud, which should not be taken for the cupric reduction.—Dr. Purdy, *North American Practitioner*.

#### STRYCHNIA INJECTIONS FOR INEBRIETY.

In the *Montreal Medical Journal*, June, we find a very interesting report by Dr. McConnell on this subject, part of which we append. From perusal of his detailed reports we would draw a rather more favorable conclusion than Dr. McConnell has expressed; since the patients were all for many years drunkards, and yet as a result of treatment some were abstainers

after many months. At any rate the strychnia seems to give the patient a chance for a new start. In some cases moral, religious and domestic influences may make this new start permanent, as they sometimes work a cure even when the invigorating and nerve-resting power of the strychnia has not been invoked. For obstinate cases forcible retention in hospital is certainly needed.

Dr. McConnell says:

I have treated during the last 15 months some 30 cases, 25 of whom received the full course of injections; the results will, I think, demonstrate what benefit we can obtain from it in this form of narcomania. Due attention was paid in each case to the associated derangements and to the constitutional peculiarities. The patients all came to the office for treatment, and although recommended to abstain from further drinking were allowed to take liquor if they desired it. The dose given subcutaneously varied from one-thirtieth to one-sixth(?) grain twice daily for ten days, then once daily for ten days, the highest dose being reached about the third or fourth day and continued to the close of the treatment. This being nearly in accordance with Spitzka's experiments, that to maintain its action the doses of strychnine must be in the beginning increased, and later the interval increased and the doses lessened. The border line of tolerance was reached in most cases when one gramme was used of a solution containing 12 centigrammes strychn. nitrat. to 15 grammes water, that is about two-fifteenth grain. Internally cinchona, peroxide hydrogen and capsicum were frequently prescribed in combination. When bromide of sodium



failed to procure sleep, paraldehyde always succeeded. In the later cases strychnine indoses of one twentiethgrain, with elixir of phosphate and calisaya (Wyeth's) was ordered to be taken once or twice daily for four or five weeks after ceasing the injections.

From the results obtained in these twenty-five cases we can learn that simultaneously with the use of this remedy the crave for alcohol in inebriates diminishes and in a few days is completely gone, and through the withdrawal of the poisonous beverages and tonic effects of the strychnine there is a more or less rapid restoration to sound physical health and of the mental powers; but as most of those treated have relapsed within from one to eleven months, the inhibiting power of the remedy is not permanent, and while it temporarily relieves the distressing and overwhelming crave for more stimulant and promotes a return to normal health and in which condition these patients may continue to remain, yet they still lack the necessary will power to enable them to avoid the dangers which they know will precipitate a return to their previous enslaved and degraded condition. So that while it is fully within the power of medical science to restore these patients to temporary health, strychnine does not—as doubtless no drug treatment ever will—prevent the possibility of further relapses, although we can always depend on it to arrest what would be a prolonged debauch if its aid is early resorted to.

That weakened will power is a result of the prolonged use of alcohol is generally conceded, as in the fact that the tendency to alcoholism is in a large percentage of cases inherited, and that it is

often as dipsomania one of the manifestations of insanity. A definite series of pathological conditions follow the continual indulgence in alcohol, differing only in degree from the milder methyl to the powerful effect of amyl alcohol; the nervous system showing the earliest and most marked disturbance, although every organ and tissue in the body eventually suffers. These and many other facts have lead neurologists to place alcoholism as a distinct disease among the neuroses.

While we have in strychnine a true antagonist to the action of alcohol, and one that will counteract its effects, the inebriate still requires aid which can scarcely be expected of drugs. He needs the mental and will power to overcome his acquired or inherited tendency to resort to narcotics. This must come from treatment which seeks first to restore all the abnormal conditions of the patient, whether due to alcohol or otherwise. Then strict abstinence, which must be aided by moral suasion, the diversion of continual employment, and the education of the mental and moral faculties to a higher status; even the influence of hypnotic suggestion may be applied in suitable cases, as has been done recently with a fair measure of success. And when these means fail, then institutions where voluntary or forced detention can be secured and where all the present known means can be most successfully applied, must be the only hope of restoring these unfortunate subjects of narcomania.

#### IZAL.

This new substance is a by-product obtained in coke manufacture. Dr. Clarke, assistant surgeon to St. Barthol-

omew's Hospital, writes in a recent number of the *Lancet* (July 1) that he has found it useful in the dressing of fresh clean wounds, of old, foul sinuses, etc. His conclusions are:

From a consideration of Dr. Klein's experimental researches in connection with the substance and from my own practical experience of it I have no hesitation in saying that the antiseptic in question seems likely to prove more efficacious practically than any at present known. It will be obvious to anyone who peruses critically the account of the cases in which I have employed it that in many of the instances referred to it was put to a very severe test and that by its aid some excellent results were obtained. At the same time it is equally clear that its behavior under all circumstances must be submitted to the test of a more lengthy experience before one can be in a position to predict that exact place which it is destined to take amongst the antiseptic fluids of the future. One thing, however, is certain—viz., that the surgeon will rejoice to hear that at last an antiseptic has been found which is easy to use, does not irritate his own hands or his patient's skin, and is at the same time by far the most powerful with which he is yet acquainted.

#### SUGAR TESTING.

In the *North American Practitioner*, June, Dr. Purdy, of Chicago, writes:

The following suggestions may aid the observer in avoiding errors and reaching accurate results. 1st. Before testing always thoroughly cleanse all utensils to be employed in the analysis. 2d. In using the copper tests, always employ at first a minimal amount of the

suspected urine, gradually increasing until reaction be obtained or the stated limit be reached. This method greatly decreases the risks of reduction by other substances than sugar in the urine, and moreover it gives a rough idea of the quantity of sugar when present. 3d. If any doubt arise as to the presence of sugar in the suspected urine after the application of a routine test, an appeal should be made to one or more of the others mentioned. For this purpose the phenylhydrazin test is desirable above all others, both because of its exceeding delicacy and its present known property of reacting with few other substances than grape sugar.

#### HÆMOPTYSIS FROM ANEURYSM.

At a recent meeting of the Medical Society of London (*Brit. Med. Jour.*), Dr. Smith read a paper on the occurrence and diagnostic significance of hæmoptysis in aortic aneurysm. The hæmoptysis might be due either to bursting of the sac or to pressure of the sac on the bronchi or lungs. There was ample evidence that rupture of the sac might not prove immediately fatal, but his remarks applied only to hæmoptysis dependent on pressure, which might be exerted on the air passages, on the blood vessels, or on the lung tissue, or the hæmoptysis might be secondary to the heart lesions associated with aneurysm. Pressure on the air passages led to local congestion of the lining membrane associated with paroxysmal cough, scanty expectoration of bronchial mucus, tinged with blood, running on to the more serious and characteristic lesions. He referred to one case in which the hæmoptysis was due to pressure on the pulmonary artery with

consequent engorgement. In another case the aneurysm led to regurgitation of blood through the stretched aortic ring, though the valves were healthy. In the case of a man at present under observation at the London Hospital there were symptoms of aneurysm pressing on left bronchus. Two years ago these advanced signs were absent, and almost the first sign was the expectoration of bronchial mucus tinged with blood. This symptom might prove useful as an early diagnostic sign in these cases if the existence of any disease of the lungs, kidney and heart capable of accounting therefor were excluded.

#### PENALTIES FOR ABORTION.

As is well known, in England and in Ireland the punishment is penal servitude for life, or for any less term, or imprisonment; whilst if the mother of the child should die in consequence of this unlawful act the crime becomes constructive or legal murder. In 1875 Alfred Thomas Heap, a Manchester abortionist, was convicted of the murder of a woman. He had used a Manchester spindle, with which he had transfixed the gravid uterus. He was found guilty, but was recommended to mercy by the jury. As, however, they were unaware that he had already served five years' penal servitude for procuring abortion, the recommendation was disregarded and he was executed. Since then there have been many convictions and heavy sentences, but still the crime goes on. In Scotland the punishment is arbitrary; in France, Spain, the German Empire, Austria, Hungary, Italy, Russia, Norway, Sweden and Denmark—in short, throughout the whole of Europe—the crime is punished with imprisonment for from six months to twenty years or for life.

In Sweden the penalty is death if the mother dies, and in Russia the mother, if a consenting party, may be exiled to Siberia; in the Dominion of Canada the penalty is imprisonment for life; in Nova Scotia, Quebec, Ontario, British Columbia and in Prince Edward Island it varies from imprisonment for two years to for life; in New Brunswick the penalty is death; in Australia and New Zealand the punishment is very severe, ranging from two years' imprisonment to penal servitude for life; in the United States it is punished with fines ranging from 100 to 5000 dollars, with imprisonment for long periods and with death; so that in all parts of the civilized world this crime is regarded as a grave one and is punished with more or less severity. Every medical practitioner who may have the opportunity of doing so should aid in bringing to justice the miscreants, both male and female, who live and thrive on this abominable trade, too often at the risk of the lives of the unhappy women who resort to them.—*Lancet*.

#### MEAT EATING AND BAD TEMPER.

One deplorable result of excessive meat eating in England is the ill-temper which is a chronic complaint among us. "In no country," declares Mrs. Ernest Hart in the *Hospital*, "is home rendered so unhappy and life made so miserable by the ill-temper of those who are obliged to live together as in England. If we compare domestic life and manners in England with those of other countries where meat does not form such an integral article of diet, a notable improvement will be remarked. In less meat-eating France urbanity is the rule of the home, in fish- and rice-eating Japan harsh words are unknown, and an exquisite politeness to one another prevails even among the



children who play together in the streets. In Japan I never heard rude angry words spoken by any but Englishmen. I am strongly of opinion that the ill temper of the English is caused in a great measure by a too abundant meat dietary combined with a sedentary life. The half oxidized products of albumen circulating in the blood produce both mental and moral disturbances. Brain workers should live sparingly if they would work well and live long. Their force is required for mental exertion, and should not be expended on the task of digestion for 'they should remember that the digestion of heavy meals involves a great expenditure of the nerve force.' The healthful thing to do is to lead an active and unselfish life, on a moderate diet, sufficient to maintain strength and not to increase weight.—*British Medical Journal*.

### Medical Items.

There is an association of physicians and surgeons in Philadelphia for the purpose of entertaining visiting physicians.

In Edinburgh and Glasgow the professors filling the chairs of medicine, surgery and obstetrics receive a salary of \$3,000 per annum.

Paper stockings are a new German invention. A Berlin shoe trade journal says that the stockings are made of a specially prepared impregnated paper stock, which, it is claimed, has an extraordinary effect on perspiring feet. The moisture is absorbed by the paper as rapidly as it is formed, and the feet remain dry and warm, while the constant temperature maintained in the shoes is

said to be a great preventive of cold.—*Jenness Miller Monthly*.

The mysteries of vegetable life are not yet all explored. An Indian botanist has made experiments which induce him to say that some plants can see. Whether the inference can be accepted or not, these experiments go to show that the plants made an effort to reach supports placed a little distance, and grew towards the supports, wherever placed. The plant was a convolvulus, and when a long pole was placed near it, and in such a way that the tendrils would have to turn away from the light to reach it, they invariably did so, and within a few hours trained about it. That certain plants have the sense of touch is well known. The leaves of several species of Mimoseæ exhibit a peculiar irritability when touched or shaken. The ancients believed that trees were inhabited by nymphs; and Tasso, in his great epic of "Jerusalem Delivered," makes trees groan and bleed when wounded.—*Albany Times-Union*.

Singer (*Centralblatt für Chirurgie*, No. 32, 1892) describes a method of curing in a short time wounds of the cranial bones, accompanied by stripping off the periosteum. After the wound has been treated antiseptically for several days by moist sublimate or carbolyzed dressings, the external table, or a portion of it, is chipped away by means of a chisel. A moist bandage is then applied. In two or three days healthy granulations appear, and in a very short time the whole wound is converted into a surface of granulation, which promptly cicatrizes. Even in suppurating wounds this method may be carried out. Of course in phlegmonous and progressive inflammatory processes such procedure is not to be

recommended, the bones being treated upon general surgical principles. By this treatment wounds of the skull, which would require weeks, or even months, to heal, are completely cicatrized within a few days — *Therap. Gazette.*

Prof. Moissan delivered a long expected practical lecture on diamond-making, in the large hall of the Conservatoire of Arts and Métiers, Paris. Before an audience of 600 persons the lecturer executed the various experiments explained at the Academy of Sciences during the past three months. The results obtained created a good deal of enthusiasm amongst the audience. By a series of manipulations M. Moissan showed how Violle had established that great fact of electro-chemistry—viz., that the temperature of the electric arc is independent of its magnitude and always equal to about 5,000° F. He also explained that natural diamonds must have been formed by crystallization, under pressure, of carbon dissolved in iron, the greater number of diamonds burned leaving a certain quantity of iron as ashes. He concluded by saying that the scarcity of large diamonds is beneficial to mankind, as it would have been a calamity to all if the useful commodity coal had been transformed into a substance which is only the pride of the wealthy.—*Chemist and Druggist.*

Dr. Paterson has received from Mr. A. Bayne, who went out to the Canary Islands for the benefit of his health, an interesting addition to his extensive museum. This is a Guauche skull. These people were the original inhabitants of the Canary Islands, and when the Spaniards took possession they were unable to

overcome the Guauches, who betook themselves to caves. In order to exterminate them the Spaniards let themselves down from the rocks they could not scale and set fire to the whole bush in front of the caves, and so smoked the people to death. The caves were afterwards so carefully shut up that they are only now being found. The skull sent to Dr. Paterson was found some time ago in a cave in Teneriffe, the largest of the Canary Islands, where there were forty others of men, women and children. It is supposed to be the skull of a man between forty and fifty years of age. Dr. Paterson says it is remarkable for its peculiar formation and fineness of tone. The only other specimen sent home is in the museum of the Royal College of Surgeons. "The Guauches," he adds, "are an extinct race, and the skull is the largest and finest in my collection."—*Lancet.*

From the columns of the *Richmond Dispatch* we learn that at the meeting of the Board of Visitors of the Medical College of Virginia July 12th, Dr. J. B. McCaw was elected president *pro tem.*, Judge Crump, the president, being unable to attend on account of legal engagements in Wytheville. The following members were present: Dr. D. W. Lassiter, of Petersburg; Rev. J. J. Lafferty, D. D., of Richmond; Dr. R. E. Moore, of Wytheville; Colonel Robert B. Berkeley, of Pulaski; Dr. James B. McCaw, of Richmond; Mr. George B. Harrison, of Boyce; Dr. Herbert M. Nash, of Norfolk; Dr. John S. Perdleton, of Marion; Colonel J. B. Purcell, of Richmond; Mr. Wyndham R. Meredith, of Richmond; Dr. Thomas H. Barnes, of Elwood; Dr. Thomas P.

Matthews, of Manchester, and Dr. J. R. Baylor, of Greenwood.

Drs. McCaw and Lassiter presented, in accordance with a resolution of the board, a tribute of love and respect to the memory of the late Dr. S. Dorsey Cullan, dean of the faculty and professor of surgery, which was ordered to be placed upon the records.

Upon motion the board changed the title of the chair occupied by Dr. William H. Taylor from professor of chemistry and pharmacy to that of chemistry and toxicology.

The resignation of Dr. J. S. Wellford as professor of diseases of women and children was received and accepted and Dr. Wellford was thereupon unanimously elected emeritus professor of the same chair. Dr. J. W. Long, of Randleman, N. C., was then unanimously elected to fill the chair vacated by Dr. Wellford.

Dr. Long was born in Randolph County, N. C., in 1859. He received his diploma from the medical department of the Vanderbilt University in 1883, and later graduated from the medical department of the University of Nashville. He has pursued post-graduate studies in the New York Polyclinic and the various hospitals of that city, and is a member of the Randolph County Medical Society, the North Carolina State Medical Society, and the Southern Surgical and Gynecological Association. He has contributed liberally to the literature in the transactions of the above-mentioned societies and to the *North Carolina Medical Journal*, the *Maryland Medical Journal*, the *American Journal of Obstetrics*, and various other periodicals. Dr. Long has won for himself the reputation of being a careful observer, a

skilful practitioner, and a conscientious and honest worker in his practice.

For the chair of diseases of the eye, ear and throat, applications were received from Dr. Angus Bethune Patterson, of Atlanta, and Dr. Charles M. Shields, of Richmond. Both of these gentlemen presented testimonials of the very highest character, and upon a vote being taken Dr. Shields was declared unanimously elected.

For the chair of materia medica and therapeutics the following names were before the board: Dr. William James Cox, of Pennington, Ga.; Dr. George A. Renn, of Raleigh, N. C.; Dr. Robert H. Stowell, Jr., of Margarettsville, N. C.; and Dr. J. N. Upshur, of Richmond. The last named recently resigned this chair for the purpose of applying for the chair made vacant by the resignation of Dr. J. S. Wellford, but it having been thought best by the faculty to encourage gentlemen from a distance to compete for the college professorships, Dr. Upshur withdrew from the contest for Dr. Wellford's chair and asked to be re-elected to his old position—that of materia medica and therapeutics. On a call of the roll he was unanimously elected.

The board desiring to advertise the chair of pathology and bacteriology for a longer period, postponed filling the same until its next meeting. In the mean time the faculty were instructed to appoint a gentleman experienced in these sciences to teach the same during the coming session.

The outlook of the largest class in the history of the college is of the brightest character. The hospital under the care of the Sisters of Mercy is rapidly approaching completion and will be ready for the reception of patients September 1st next,



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## Original Articles.

### ENDOMETRITIS; CAUSES AND TREATMENT.\*

BY J. M. HUNDLEY, M. D.,  
OF BALTIMORE.

Chief of Clinic, Diseases of Women and Children,  
University of Maryland.

Of all the ailments peculiar to women, endometritis, in one form or another, is the most frequent. The process may be confined to the cervix, which is the most common variety; or it may involve both the cervical and corporeal membrane at the same time, or the corporeal may alone be involved.

I shall not take up the time of the society by narrating the various symptoms attending acute or chronic endom-

etritis, for all of us are more or less familiar with them. This short paper is based upon two years' work in the Dispensary and Hospital of the University of Md., and my private work. My attention was first called to the importance of the subject about two years ago when a married colored woman came into our department with the history that she had been married two years and had not become pregnant, which she greatly desired. She had a profuse leucorrhœa, and her menses were regular and without much pain. Upon digital examination we found no disease of her appendages—uterus in position, but slightly lower than it should be. By speculum examination we found a muco-purulent discharge issuing from the os, lips of the os everted and red. Diagnosis: chronic endometritis. Treatment: application of

\* Read before the Medical Journal Club of Baltimore, April 1st, 1893.

iodine within the uterine cavity. I forgot to say probe had been passed to see position of uterus, size of cavity, sensitiveness and vascularity of the membrane. In twenty-four hours I was sent for at my office to see this woman. She remained in bed two weeks. Her entire pelvic roof was a mass of exudate, solid as plaster-of-Paris. In other words, she had a salpingitis and pelvic peritonitis. This case so impressed me that now we never use a probe to make a diagnosis, and rarely do we make applications within the uterus in routine dispensary work.

I shall have but little to say of acute endometritis. Aside from puerperal, gonorrhœal and septic cases I believe taking cold, overfatigue, undue violence in coitus and overindulgence produces the trouble, but not in such violence. They produce more of a congestion, and the process is catarrhal and non-purulent. The treatment is simple for the class of cases coming under the second head—that is, those not the result of septic, gonorrhœal or puerperal processes—rest in bed, sedatives, poultices over the uterus, and possibly vaginal douches, if they give relief.

My object is to speak more at length of chronic endometritis. As said in the outset, we may have the disease confined to the cervical membrane alone.

It is this form that is commonly called uterine catarrh. We may have it existing as corporeal (not involving the cervix); this is rare. When we have the corporeal it has been produced by extension of the process from the cervix, as a general rule. What are the causes of chronic endometritis? One cause is the acute, ending in the chronic form. Another is malpositions of the uterus, such as versions

and flexions. Correct the malposition, a cure is effected. We will have but little to say of this form of endometritis. The discharge is generally of a catarrhal nature; no pus is present; it is usually non-irritating and its treatment is of little moment.

The class of cases having for their cause septic, puerperal and gonorrhœal processes are the cases calling for the most careful treatment. I should like here to state again that I believe there are cases of endometritis brought about by a strumous diathesis—by the eruptive fevers, exposure to cold, debilitated conditions of the system, loss of rest, etc., or, in short, where a young girl comes with this history: that she is 22 years of age, menstruated five years, painlessly until within the past six months, when she began to have some pain at the periods; between them she has backache, some leucorrhœal discharge, at times tinged with blood. At the time she consulted me she was using a vaginal douche. She came to me for an examination, which I refused to do. I ordered her to discontinue the douche and looked after her general health; that was in October. With no other treatment she got well. When I see such cases and in women beyond reproach I must admit that such causes do produce endometritis. They are the cases that get well with the simple treatment of rest and looking after the general health. Of the causes embraced in the one alluded to as puerperal, all of us are familiar. We frequently see puerperal septic endometritis—if not in private practice, certainly in dispensary work—following normal labors with or without lacerations of the the cervix, and after abortions, more especi-

ally produced abortions. Those septic cases not occurring after labors may be produced by the introduction of unclean sounds—making of applications, operations on the cervix, etc. With the gonorrhœal form we are familiar.

Treatment.—I have already outlined the treatment for those cases characterized by a milky non-irritating discharge. It is rather an increase of the normal mucous secretion, a congestive rather than an inflammatory process. These are the cases the result of debility, sedentary habits, versions, flexions, etc. They are easily cured; but one thing we should remember in dealing with these comparatively mild cases—it is this: they can be easily made one of the septic type, and when once that condition exists the woman is never free from the possibilities of a laparotomy. In the making of applications within the uterus I have often felt it was a mere sham. It is almost an impossibility to get the canal free of the tenacious mucus with a cotton-wrapped applicator, and if it is not clean the iodine or whatever is used is enveloped and not a particle comes in contact with the diseased membrane.

In my judgment there is only one way to effectually apply medicaments to the endometrium. First a blunt curette is used to scrape away all secretion and the application is made with a glass pipette as recommended by Skeene, or a cotton wrapped applicator; after the application cotton tampons saturated with boroglyceride are introduced; they aid very greatly in the cure. Every 3 or 4 days is often enough to make the applications.

It will take months to effect a cure even in the milder cases—and since I have had two cases of tubal and ovarian

disease, the result of intra-uterine medication, I never attempt to treat the uterine mucous membrane by applications if I see a muco-purulent discharge issuing from the cervix. I do not think we can have this matter too firmly impressed on our minds—I mean the intra-uterine treatment of a case of endometritis having a muco-purulent discharge; the woman is safer left alone. The treatment now used in the Maryland University Hospital is dilatation, curettement and packing with iodoform, or sterilized gauze; a cure is usually effected in about six weeks. This treatment is resorted to irrespective of existing complications. I mean to say if a case applies for treatment with a profuse muco-purulent discharge, inflamed vulva and vaginal mucous membrane and the tubes perceptibly enlarged, we do not hesitate, under the strictest antiseptic precautions, to dilate thoroughly, and even incise the mucous membrane of the cervix, to obtain and maintain a patent canal and thereby secure free drainage. After that we wash out the cavity thoroughly with hot sterilized water, and with a sharp curette cut away the diseased membrane; and lastly pack, firmly, the cavity with gauze, either iodoform or plain sterilized. This may have to be repeated—that is, the packing. It is usually left in 48 hours.

I am sure cases can be cured in the old way, but when the length of time required is taken into account, and above all the constant and serious risk to which the woman is exposed each time you attempt the intra-uterine application, I can but believe that this is the best treatment. I had gotten together the histories of twenty cases to accompany



this report, but feeling it would subserve no useful purpose and take up the time of the society, I have contented myself with the foregoing remarks. This is not a new treatment of mine, I am simply following the lead of such men as Polk, Mundé, Pryor and others. This paper could be extended many pages.

The views expressed by Dr. Pryor regarding the pathology of the disease is most interesting and instructive. And it should serve to impress indelibly upon our minds the one fact that the cavity of the uterus, in this disease, is a septic cavity, and if in making applications, introducing sounds, etc., we abrade the surface and give a point of entrance for this septic material we frequently have cases of peritonitis as the result. There are two channels through which this infection may and does travel: one is through the tubes; the other, and thought to be the most important, through the lymphatics of the uterus; these lymphatics end as tubes in the broad ligament. The fallopian tubes when infected usually have their fimbriated extremity sealed up, and thereby cease to be a potent source of infection. This is not true with the lymphatics; their spaces are not easily occluded and are therefore constant carriers of infection.

Dr. J. Hutchinson reports a case of leprosy cured by the long continued use of arsenic and total abstinence from fish diet. The patient had enjoyed three years of immunity after the disappearance of the last lesions.—*Ex.*

The urethritis caused by bicycles bears a close family resemblance to gonorrhœas contracted in water closets or bad beds.—*Medical Fortnightly.*

# REPORT OF A CASE OF DETACHMENT OF THE LIGAMENT OF THE PATELLA. TREATMENT BY SUTURE. RECOVERY.\*

BY WILLIAM BARTON HOPKINS, M. D.,  
Surgeon to the Episcopal Hospital, Philadelphia.

Last November a large healthy man, forty-five years of age, was admitted to Episcopal Hospital. He had stumbled and fallen, striking his right knee with great violence upon a cobble-stone. Examination of the joint revealed a change of its natural contour. It was flattened anteriorly, and on flexing the leg upon the thigh, the form of the condyles of the femur became clearly exposed, as shown in the illustration. There was a moderate fluctuation from effusion. The entire patella could be felt and seen drawn well up the thigh. No fragment of bone could be detected above the tuberosity of the tibia. As it was, therefore, evident that the patella had been torn away from its ligament, it was decided to open the knee-joint at once. The patient was etherized, and after the preparation of the parts concerned the seat of injury was laid bare by a longitudinal incision in front of the joint about seven and a half inches in length. Not only was the condition of affairs looked for found, but in addition to the detachment of the ligament from the patella, the whole fibrous covering of the latter was found to have been ripped off and to have remained attached to the ligament. The patella was readily brought down to its natural position between the condyles,

\*Read before the Philadelphia Academy of Surgery, May 1st, 1893.

and but for its bare anterior surface was found to be intact.

Very complete and durable coaptation was effected by the introduction of eight interrupted silkworm-gut sutures at the following points: Three king sutures upon which the greatest reliance could be placed were carried through three small drill holes at the apex of the bone, uniting it with the stump of the ligament. The upper margin of the aponeurotic hood was then attached to the fringe-like fibres of the tendon of the quadriceps extensor with which it had been continuous, while its lateral margins were sutured through drill holes on either side of the patella. As all of these silkworm sutures passed through a very stout tendon, the approximation of the parts was not only snug but very strong. After thoroughly cleansing the knee-joint the long wound was closed, catgut drain being in its upper and lower angles. A liberal gauze-dressing was applied, and a long posterior splint retained to the limb. Three days after the dressing was removed on account of a slight rise in the patient's temperature, but it was found to be quite dry, except at the points of drainage, where a few drops of blood-stained synovial fluid escaped. The joint was free from redness, fluctuation and pain. In a month the patient was allowed to get into a wheeled chair. The natural contour of the joint was entirely restored.

Five months after the accident he was allowed to begin to flex the knee with considerable force, and it is interesting to observe that almost all the motion he has now has been acquired within one month. As will be seen, he walks without a limp, and his limb has

almost completely regained its strength. The patella is felt to be freely movable, and there appears, therefore, to be no obstacle to the restoration in a short time to the normal function at the joint.

So far as I can learn, sixty-six cases of rupture of the ligamentum patellæ have been reported. This number includes detachments of its upper and lower extremities as well as ruptures in its continuity. Of these I have had an opportunity of referring to fifty-five, including thirteen cases which were collected by Dr. Sands from the records of four hospitals in the City of New York.

In all the cases where treatment was employed, some appliance appropriate for fracture of the patella was used with results stated to be fair or good, save three. In two of these the knee-joint was opened and the parted ligament sutured to some fibrous tissue attached to the tuberosity of the tibia, by Sands, of New York, and to a similar structure at the apex of the patella by MacFarlane, of Toronto, with excellent results. In both these cases silver wire was used. In the third case operated upon the stump of the ligament and some fibrous tissues at the apex of the patella were scarified long after the occurrence of the injury, but no sutures were used.

Two very remarkable cases are reported by Mr. Shaw, of London, of simultaneous rupture of both ligaments. In one, both ligaments were detached from the apices of the patellæ, while in the other case both parted from their insertions in the tuberosities of the tibiæ.

While, technically, even a very minute fragment of bone remaining in contact with the detached ligament

would, if the separation occurred at its patellar extremity, constitute a fracture of the latter, a similar condition at its tibial insertion could hardly be classified, without causing confusion, as a fracture of the tibia. It would therefore seem proper to class such an injury as rupture, or, I think better, as detachment of the ligament, if a greater part of its rent surface is tendinous, not bony.

In a very large proportion of cases recorded the lesion was caused by muscular violence. The case now reported I incline to attribute to the combined forces of direct impact and muscular contraction acting simultaneously; the cobblestone forcing the apex of the patella backward, while the tensile strain was applied by the muscles of the thigh. I do not think that the tendinous covering of the bone could have been stripped off by either direct violence or muscular contraction alone. Regarding the advantage in operating at once or at a later period: if opportunity for the former offers, I see no reason for delay, provided there is no severe bruising of the soft parts adjacent, for the inflammatory reaction from the mere rupture is in most cases noticeable slight, and coaptation can be far more satisfactorily effected before, than after adhesions have formed.

As the special feature of this case is the stripping of the bone, it would be of great interest to know if a similar injury had ever happened before, but as its existence could not be revealed except by operation, whether it unique or not must remain a matter of conjecture. While it might have added to the risks of necrosis of the bone from impairing

its blood supply had suppuration occurred, it certainly aided materially in securing an approximation well equal to resisting any accidental strain that might be put upon it during the process of repair.

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## THE DETECTION OF BLOOD IN THE FÆCES.

In its Berlin letter the *Bulletin of Pharmacy*, June, presents the following convenient test:

Although the spectroscope is an unerring instrument in the detection of blood, a good apparatus is not always at hand, and the want of an equally delicate chemical test, especially for the presence of blood in the contents of the stomach and intestines, is frequently felt. Deen's test, consisting in a blue coloration when blood and turpentine are added to a solution of guaiacum resin, is not applicable, because the normal stools as a rule give a positive reaction. Weber finds, however, that the disturbing constituents are excluded if the fæces or urine be first treated with a third of their volume of glacial acetic acid, and the acid solution shaken out with ether. Ten drops guaiacum tincture and 20 drops of turpentine added to the ethereal solution give a blue-violet coloration if blood is present, whilst the mixture remains reddish-brown (sometimes with a green tinge) in its absence. The reaction depends upon the ferruginous constituent of the blood, hæmatin.

The Queen of England, every year on her birthday, confers titles of different grades upon a certain number of her subjects, and the medical profession generally receive a few. This year, Dr. Charles Cameron, M. P., has been made a baronet, and Dr. B. W. Richardson, Dr. W. O. Priestley and Mr. G. A. Pilkington have been knighted. They will all in future have the prefix "Sir" to their names.

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BALTIMORE, AUGUST 5, 1893.

**Editorial.**

## COMPRESSED MEDICINES.

We are informed that apparatus now in use for the compression of medicines, complete and complex though it may be, is the subject of constant inventive thought and ingenuity for the purpose of farther improvement.

Regarding the convenience of form and portability of compressed medicines, there are probably no better judges than the traveler and explorer, who, like Stanley and Lovett Cameron, have carried them into the wilds of Africa. Surgeon Parke, of the Stanley exploration party, has spoken highly of the "tabloids" of a London Company, in his book "My Personal Experiences in Equatorial Africa." He says of them that they are "remarkable not only for their efficiency and constancy of strength, as I have repeatedly noticed, but also for extreme convenience of transport and rapid dispensing. I hope that the medical de-

partments of Her Majesty's services may see their way to adopt this form of medicine. I can say with confidence from the experience of over ten years in the medical staff of the army, both at home and abroad, in peace and war, including this expedition, that one man could carry a larger quantity and of more efficient medicine in the tabloid form than ten men can manage in the present cumbersome system used by the services. But the most convincing ground of appeal to the authorities must be that of economy in expenditure—for the estimates would be lessened—as *one medical officer could do the work of two.*" He adds that there are other arguments in favor of these compressed drugs, such as their compactness—they occupy very little space—and their permanence of strength during long journeys or campaigns. It is a little remarkable that the armies and navies of the world have not more generally than is the case discovered the suitability of compressed medicines to their needs not only in war but in peace. They belong to the age of repeating arms and smokeless gunpowder.

## SOME POINTS ABOUT CLINICAL THERMOMETERS.

In a report of the Observatory of Yale University, kindly sent us by its Board of Managers, we find some observations concerning the work which it has undertaken in testing clinical thermometers. For a certain charge, makers of these thermometers may send them for comparison and certification by the Yale authorities.

The report before us states that but a small percentage of the instruments



sold are sent for certification. Yet, of these select instruments sent, from twenty-five to seventy-five per cent. are rejected as inaccurate. By necessary inference therefore we must believe the majority of the clinical thermometers sold by makers are extremely unreliable.

Some interesting facts are given in the report concerning the self-registering index.

In those forms where the index is a short column of mercury—one-third to one-half an inch long—separated from the rest of the mercury by a small bubble of air, the index is often lost by being thrown down into the bulb, the bubble escaping into the attenuated atmosphere of the tube, and when the index is restored the separating bubble is not likely to be of the same dimensions, and the temperature indications will not be the same as with the former bubble. The difference in the lengths of the tube occupied by the old and new bubbles will account, approximately, for the differences in the readings. The bubble should always be as small as is consistent with its function of separating the columns of mercury. The tube should extend sufficiently beyond the maximum readings required, that the compressed atmosphere at the top of the tube may not force back the index, when the support of mercury in the bulb is withdrawn by cooling.

In those forms where the "Indestructible index" is maintained by a "trap" near the bulb, the various constructions of this trap may, at certain points, cause the index to drop irregularly when the mercury below the trap has contracted, or may occasion a motion of the index by jumps; in fact, in most of the reliable

instruments of this form, it is merely a question of the number of jumps taken by the index in rising one degree;—most of those in which the index rises perfectly smoothly and without jumps will justify the suspicion that the index will drop, as soon as the mercury in the bulb contracts from the trap. While the index is rising freely the motion may appear continuous, but when the index is within a degree or two of coming to rest and rising slowly, the jumps may, usually, easily be counted. Our recent practice has been that, when these jumps average  $0^{\circ}.1$  or less, and the readings repeat themselves, throughout, within the prescribed limit of accuracy, the usual certificate is given; if the jumps average more than  $0^{\circ}.1$  and less than  $1^{\circ}$ ,—the readings repeating themselves as before, we modify the certificate by making the limit of accuracy  $\pm 0^{\circ}.2$  on the same certificate form; and when the jumps average more than  $1^{\circ}$ , we give no certificate. The process of producing the the trap leaves its walls in a somewhat unstable condition, so that moderate concussions may cause particles of glass to separate, which particles, acting as a plug, may temporarily sustain the index, which, when the plug is dislodged, may drop. The contraction here is so small, and the particles of glass so fine, that it is not always easy to detect them. The same dropping of the index may be due to the varying effect of air in the trap.

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"When I was young we prepared students for life; now we prepare them for examinations," is a bit of truth from Jules Simon.—*Ex.*

**Reviews, Books and Pamphlets.**

*Weekly Abstract of Sanitary Reports*, vol. vii, 1892. Issued by the Supervising Surgeon-General M. H. S., under the National Quarantine Act of April 29, 1878. Washington: Government Printing Office, 1893.

*Traumatic Lesions of the Spinal Cord*; by GEORGE J. PRESTON, M. D., Professor of Physiology and Diseases of the Nervous System, College of Physicians and Surgeons, Baltimore. Reprint from *Medical News*, March 18, 1893.

*St. Louis Medical College Fifty-second Annual Announcement*, 1893-4, and Catalogue for 1892-3. St. Louis Mo. Nixon-Jones Printing Co.

*Some Further Remarks on Elastic Constriction as a Hæmostatic Measure* (with a letter from Professor von Eschmarch); by N. SENN, M. D., Chicago, Ill., Professor of Surgery, Rush Medical College, Professor of Surgery, Chicago Polyclinic, etc. Reprint from *Medical Record*, May 20, 1893. New York: Trow Directory, Printing and Book-binding Co., 201-203 Twelfth Street, 1893.

*Importance of Arterio-Sclerosis in the Etiology of Posterior Spinal Sclerosis*; by GEORGE J. PRESTON, M. D., of Baltimore. Reprint from *Medical News*, July 8, 1893.

*Special Consular Reports; European Emigration in 1890*; by F. L. DINGLEY. Issued from the Bureau of Statistics Department of State. (Copies furnished on request by the Secretary of State). Washington: The Government Printing Office, 1890.

**Pan-American Congress.****OFFICIAL DELEGATES.**

Practically all of the Governments have appointed official delegates to the Congress in response to the invitation by the President of the United States. The U. S. Government will be represented by six delegates. The larger cities of all the Latin-American countries have appointed delegates to participate in the proceedings of Sections on Hygiene, Climatology, Demography, Marine Hygiene and Quarantine, and similar appointments will be made by the cities of the United States. Seventy-six similar delegates have so far been appointed by the governors of States in the United States. A large number of delegates have been chosen by the medical colleges of the United States and other American countries to attend the Section on Medical Pedagogics, under the Presidency of Professor J. Collins Warren, of Boston.

**Medical Progress.****ANGINA LUDOVICI.**

In the *Lancet* (June 3d) Dr. Gibson reports a rapidly fatal case of this disease:

A man aged forty-nine, a moulder, sought advice at the out-patient department of the Victoria Infirmary, Glasgow, on March 6th, 1893, for swelling of the neck. He informed me that his trouble began about noon on the previous day, when he noticed a fulness beneath the lower jaw when he was going to shave. He did not shave, on account of a scab on the side of the neck below the jaw, which had commenced a few days before

as a pimple. During the afternoon and evening the swelling rapidly increased in size, extending up the sides of the neck behind the jaw and on to the chest. During the night he slept but little, feeling "hot and cold by turns," but had no distinct shiverings. He had been a heavy drinker and had been drunk on the evening of the 4th. His previous history was unimportant. On examination there was marked swelling of the tissues beneath the jaw, extending down the neck and front of the chest and upwards behind the angles of the jaws as far as the zygomata. In both these latter situations there were lines of demarcation corresponding to the attachments of the deep cervical fascia, to the rami of the jaws and to the zygomata respectively. The swelling was very marked below the jaw and extended around the neck. There was perceptible enlargement of the salivary glands. No lymphatic glands could be felt. The skin was of normal color. There was no pitting on pressure and no pain on firm palpation at any part of the swelling, which felt firm and elastic. The floor of the mouth was considerably thickened, but the tongue was not swollen nor raised to any perceptible extent. There was no congestion of the fauces, but there was slight dyspnoea. Just beneath the jaw on the right side there was a scab three quarters of an inch in length and a quarter of an inch in breadth, with a pustular margin, very like a variola pustule, but having no areola. There were no red lines running from it. The circumference around the neck was twenty inches and a half and just below the zygomata twenty-two inches. His temperature was 97.8°. Tracheotomy

was done for obstruction to the respiration, but the patient died with dyspnoea and cyanosis.

In commenting upon the case, Dr. Gibson points out the following interesting points in this disease: 1. The slight inflammation which, even when it exists, disappears after a day or two, and which if it persists may be looked upon as symptomatic. There was never at any time congestion of the throat. 2. The peculiar wood-like induration of the connective tissue, which will not receive impressions. The connective tissue differed from the brawny feel of the indurated tissue of commencing cellulitis, feeling more as if there were a solid jelly-like material underneath. This condition was modified somewhat after the tracheotomy, owing to the emphysema. There was never any pitting on pressure of the affected tissue. 3. The uniform spread of this induration, so that is always sharply bounded by a border of entirely unaffected cellular tissue. The disease spread uniformly, but was only at first bounded sharply at the attachment of the fascia to the zygomata and rami of the jaws, spreading later, over the chin on to the face, though not extending above the upper eyelids. There was no sharp line of demarcation along the front of the chest, the disease gradually fading away into healthy tissue. 4. The hard swelling under the tongue with a bolster-like swelling along the interior of the lower jaw, of deep red or bluish-red color. The floor of the mouth was considerably thickened, but there was no congestion of the mucous membrane. 5. The escape of the glands, although the disease attacks their cellular tissue surroundings, or may even commence in



it. None of the salivary glands were enlarged, and they all appeared to be normal in size and color, although they were embedded in the gelatinous tissue. The points of especial interest in the case are: 1. The suddenness of the onset and the rapidly fatal termination—forty-one hours after the first symptom was noticed. 2. Was the small ulcer under the jaw the originating point of the disease? The swelling was not more marked around that point than elsewhere, nor was there any sign as if the disease was further advanced at that spot. At this point one would have expected, if this had been the focus of the disease, that there would have been evidence of greater local disturbance, or at least that the ulcer would have looked markedly unhealthy. 3. The low temperature ( $97.8^{\circ}$ ) that existed on admission, although the disease must have been rapidly spreading. 4. The entire absence both of pain over any part of the swelling on palpation and of any great discomfort until the respiration was seriously interfered with. 5. Absence of gangrene of the tissues or even redness of the skin and the entire absence of pus. This, no doubt, would be accounted for by the early death of the patient—which seems to have been caused by pulmonary infarctions, the symptoms a few hours before death pointing to that condition,—the disease not having lasted long enough to have caused gangrene. Early intubation and numerous free incisions seem to be the course of treatment indicated by the experience of this case. If intubation of the larynx had been performed immediately on admission the extensive emphysema which followed the performance of tracheotomy would have been avoided.

I am indebted to Mr. Maylard for permission to report this case.

#### SCAR AND KELOID.

At the last session of American Surgical Association (*Boston M. & S. Jour.*, June 15), this subject was brought up for discussion by a paper from Dr. Warren, of Boston, who said: Lymphatics are not usually found and nerves are rarely seen in scars. Scars rarely disappear entirely. They usually remain as a fine white line, or, if the scar has stretched, as a band. Scars grow in proportion to the rest of the body. This point is not sufficiently borne in mind when performing operations on children in exposed portions of the body.

The most striking peculiarity of scar tissue is its tendency to contract. During the healing process this acts in a beneficial way. It is also the cause of the most marked deformities. This contraction of cicatricial tissue is not due to any specific contractile quality in the tissue itself but to the absorption of new formed tissue. Scars are not ordinarily painful, but may become the source of pain by adherence to structures which are sensitive.

Among the most common pathological condition observed in scars is that hypertrophic condition known as keloid. There has of late years been a growing feeling that keloid tumors spring from cicatrices more frequently than has been supposed. True keloid is found on the chest, and is an extremely rare form of growth. It seldom disappears. False keloid may develop in almost any part of the body.

Cancer not infrequently forms in cicatrices, usually after the cicatrix has existed several years.

Calcareous degeneration of a cicatrix has been reported.

A common form of complication in the life-history of scars is suppuration, which may be due to re-infection or to the awakening of spores which have long been dormant. A most common form of relapse is due to tuberculosis.

A description of the cicatrix which forms between the Tiersch grafts and the subjacent tissue was given.

Every effort should be made to limit the development of scar tissue. Animal sutures should be used if they are to be buried. Very superficial sutures should be used freely. The checking of the superabundant growth of granulations has been strongly recommended as the contractibility of the cicatrix is largely dependent upon the amount of granulation tissue which becomes organized. For projecting scars, compression has been recommended. This will often relieve the redness as well as the elevation. Unna advises friction with sand in the treatment of depressed scars. Pigmentation of scars from gunpowder may be relieved by scrubbing with a nail-brush under ether. In older cases the particles of powder may be removed by the punch devised by S. J. Mixter for this purpose.

The treatment of true keloid is discouraging on account of the persistence with which it returns. If excision is attempted, the incision should extend one or two centimetres beyond the limits of the disease, and extend to the muscular aponeurosis. Compression is recommended by many writers for the treatment of false keloid. As keloid is a connective tissue structure, it is possible that an inoculation with the virus of

erysipelas might produce absorption. Whether such a powerful remedy would be justifiable is doubtful. Tiersch grafting may be employed with advantage to broad and flat cicatricial keloids. A case was reported in which this method had been employed; and thus far (several months) there had been no return of the tumor.

Dr. Fowler, of Brooklyn, described the pathological anatomy of cicatricial and spontaneous keloid. The fact that keloid more frequently follows wounds in which there has been much suppuration suggests microbic origin. In regard to epithelioma developing in cicatrices, it was noted that it has a tendency to spread upon the surface, and rarely passes into the depths of the tissues. In the treatment of this condition there should be early and radical extirpation.

Dr. Tiffany, of Baltimore, said that in the Southern States keloid was exceedingly common; but he knew of it only as a cicatricial disease. He had never seen a case of so-called non-cicatricial keloid. In the negro the disease is prone to undergo retrogressive changes after the age of forty-five years. The affection rarely occurs before the age of eight or ten years. In the white race it may be confidently expected that keloid will go away or not progress much after the age of twenty-five years. The case of a girl, who at the age of seven years was severely burned on the face, breast and arm, was reported. She was seen by the speaker eighteen months after the accident. At this time the scar was bright scarlet and half an inch in thickness, resembling a heavy plate of cartilage. The advice was to let it alone. Twelve years later there was a white, perfectly mobile scar. The speaker was inclined to think that opera-

tive measures in young persons, either white or colored, are unwise.

Dr. Richardson, of Boston, remarked that in cases of abdominal incision it was important to bring the parts together so as to secure union by first intention. In open wounds that heal by granulation there is a great tendency to hernia.

Dr. Warren, in closing the discussion, said that the point which had impressed him was the absence of contractility in the scar tissue which formerly was believed to exist. It is absorption that produces the pulling. The scar tissue itself yields before pressure. Therefore the importance of accurate coaptation, not only to make the scar small, but to have no scar at all, and have regeneration instead of repair.

#### LYMPHANGIECTASIS OF OVARIES.

At a recent session of the Suffolk District Medical Society (*Boston Medical and Surgical Journal*, June 15), Dr. Strong showed a specimen of lymphangiectasis of both ovaries, removed from a patient about eighteen weeks after confinement.

The case before operation was considered to be one of purulent salpingitis. The history of the patient subsequent to her confinement bore out this diagnosis. Her physical condition also substantiated it. She was bedridden, weak, anæmic, almost pyæmic, with fluctuating temperature. Large fluctuating masses were felt on the right side in the position of the tube, and on the left side behind the uterus, filling up nearly the whole of Douglas's cul-de sac. It was also evident that there were many adhesions. At the operation, however, these fluctuating masses were found to be

ovaries, which I show you to-night. There are spaces in the connective-tissue widely dilated by collections of lymph. These ovaries which now you see—the left about the size of a mandarin, the right about the size of a very large English walnut—were nearly double the size when removed. The stroma was very much thickened; and on section the fluid gushed forth as if many cysts had been cut through; but it is evident, as you see, that these spaces were not distinct cystic enlargement.

The patient's convalescence was uninterrupted; and since the time of the operation she has gained steadily, and is now perfectly well. I submit the report of the specimens, as given by Dr. W. F. Whitney, the pathologist of the hospital.

“The outer surface of specimens of ovaries were dense and fibrous. On section, numerous small cysts were seen and the corpuscle tissue marked by numerous slit-like openings, from which exuded a clear fluid. Microscopic examination: the outer layer was thickened; the layer containing the follicles was considerably increased in size and dense, due chiefly to increased stroma in the central part, which was filled with markedly elongated openings, without distinct wall or lining, that is, dilated and not interspacious. Diagnosis, lymphangiectasis of the ovarian stroma.

#### ABSCESS OF THE ANTRUM OF HIGH-MORE.

J. M. Hunt, in the *Liverpool Medico-Chirurgical Journal*, publishes some important points for consideration in an interesting paper on this disease.

In the author's experience the so called



classical symptoms, (1) distention of the antrum, (2) swelling of the cheek, (3) infraorbital pain, (4) escape of pus on the sound side, are, as a rule, conspicuous by their absence. The one constant and all-important symptom is the presence of a purulent nasal discharge coming from the concavity of the middle turbinate, and escaping either by the anterior or posterior nares. Pain is, as a rule, present, and is generally intermittent in nature and supraorbital in position. As regards the intranasal condition, diffuse hypertrophy of the middle turbinate, polypoid degeneration or even true polypi in the middle meatus, hypertrophy of the mucous membrane in the neighborhood of the hiatus semi-lunaris, bare bone in the middle turbinate or at the ostium maxillary are to be found in most cases. The author regards it as justifiable to open the antrum in any patient with unilateral purulent discharge coming from the concavity of the middle turbinate in its anterior half, and constantly or at times ill smelling, if there be no obvious cause for the discharge inside the nose itself, such as a foreign body or specific ulceration. He does not regard the trans-illumination of the antral cavities by means of Voltolini's electric lamp placed in the mouth as of much practical importance, although in a doubtful case it may at times be useful. Exploratory puncture carried out through the middle or inferior meatus with a Pravaz syringe or a Lichtwitz trochar and cannula is a more reliable method. For purposes of treatment, the best plan is to open the antrum from the alveolar process, either through the socket of a tooth which has been removed or from the alveolar border. — *Amer. Jour. Dental Science.*

#### WATER FILTRATION AND CHOLERA.

In a recent publication bearing this title Professor Koch declares his opinion that the direct infection of cholera from person to person is possible but does not often occur, and that in epidemics indirect infection, especially by water, is far more frequent. The late epidemic in Hamburg was undoubtedly due to infection of the Elbe close to the point at which the Hamburg water supply was taken. The comparative immunity enjoyed by Altona is shown to be due to the fact that it has a different water supply. The Altona water is drawn from the Elbe at a point below the town of Hamburg and below the points at which Hamburg and Altona discharge their sewage into the Elbe. The Hamburg water was delivered unfiltered to the consumers; the Altona water, originally far more contaminated, was filtered through sand before delivery. Professor Koch alleges that it is to the careful way in which this filtration was carried out that Altona owed its comparative escape in the summer of 1892. The outbreak of cholera in the beginning of this year is shown to have been due to the freezing of the upper sand layer of a filter bed whilst it was being cleaned, the frozen layer thawed unequally and at the thawed places the rate of filtration was too great to completely cleanse the water. The layer of slimy matter which forms on the surface of a filter bed is the real filtering agent, but this layer gradually becomes so close that it will not let the water through and has to be removed; it is of the greatest importance that water which first passes through such a cleansed filter should not be used, since till the formation of a slime layer the fil-

tration is inefficient. Professor Koch gives the following points as essential in the management of filter waterworks: (1) the rate of filtration must not exceed 100 millimetres per hour and every single filter-bed must be furnished with an arrangement by which the rate of filtration can be controlled; (2) every single filter basin so long as it is in action must be daily tested bacteriologically; and (3) filtered water containing more than 100 germs capable of developing in a cubic centimetre should be rejected. To sum up, water filtration does not deserve implicit confidence, and, if relied upon, must be carried out with great care and under thoroughly efficient scientific control. Speaking of filters for household use, Professor Koch says he knows of no such filter which could be relied upon to act satisfactorily for any length of time and he does not advise anyone to trust to such filters when cholera is prevalent. Bored wells are spoken of in the highest terms and a useful suggestion is made by which ordinary surface wells may be converted into bored wells. An iron pump tube being put down to the bottom, the well is to be filled to the water level with shingle and then to the well edge with sand.

—*Ex*

#### MECHANICAL TREATMENT OF LOCOMOTOR ATAXIA.

Dr. Hirschberg (*Jour. Nerv. and Ment. Dis.*) draws the following conclusions as regards the utility of Frenkel's plan of treatment of locomotor ataxia:

1. It is possible to greatly improve the ataxic movement in tabetics by the method of Dr. Frenkel.

2. The gymnastic exercises explain the reason of augmentation and development

of muscular force in the affected members.

3. The exercises in making the muscular contractions under the control of the will of the patient ameliorate the incoördination.

4. In bettering the *morale* of the patient by giving him more confidence in his extremities, the persistent ideas of pathophobia which cause so much misery in tabetics are dispersed.

5. The treatment is indicated in all stages of locomotor ataxia. Best results, however, are obtained when it is instituted before locomotion becomes completely impeded.

6. Treatment is contra-indicated when the course of the disease is very rapid; that is to say, when the clinical picture is completely developed in less than two years; also, when the general condition of the patient is particularly bad, and especially when the articulations are affected.

7. The treatment does not exercise any influence on the cardinal symptoms of *tabes dorsalis*, with the exception of the ataxia.

It might be said that Frenkel's treatment in principle distinguishes three categories of movements:

1. Simple muscular contractions; that is to say, of one muscle or a physiological series of muscles.

2. Simple coördinate movements; for instance, touching the end of the nose with the index finger.

3. Complex coördinate movements, such as writing.

In applying the treatment, the practice is to begin with the simple passive movements, then gradually assume the more complex.

## INTERNAL HÆMORRHOIDS.

In a recent address before the Kentucky State Medical Society, Dr. Green (*Amer. Pract. and News*) says of the medical treatment of this complaint:

Remarkably few plans of medical treatment have been brought forward since your last session, and of these only one needs even passing notice. It has been suggested by Keith MacDonald, of Great Britain. The agent used consists of Kosobudki's modification of Unna's suppository. It is composed of chrysarobin 1 grain, iodoform one quarter grain, extract of belladonna one-eighth grain, with cocoa butter 30 grains, and glycerine in sufficient quantity for consistency. During treatment the patient is to avoid much exertion, keep the bowels well open, and introduce one suppository into the rectum each day. In the course of a fortnight the hæmorrhoids slough away, and the patient is dismissed as soon as the wounds have sufficiently repaired. It should be said of this treatment, which represents a plan more generally practised than is supposed, that it is as empirical as it is uncertain, and the less it is employed the better it will be both for physician and patient. There is always danger of extensive inflammation, sloughing, ulceration or bleeding. In a well-marked case of internal hæmorrhoids no radical cure can be effected unless the pathological condition be removed. This treatment can bring about such a result only through unlimitable sloughing; therefore its curative effect must necessarily involve an element of danger.

## CHARACTERISTICS.

A writer in the *Medical Record* comments thus of the relations of the type

of mind of the patient to the manner in which he or she furnishes urine for diagnostic examination:

All careful observers will have noted a general fact, that women bring smaller bottles than men. The sex stands out strongly here. The element of modesty enters, we have no doubt, in the production of this phenomenon.

A half-ounce vial, partly filled, rather badly wrapped up, with a white cotton thread round the neck, indicates a woman of a sensitive temperament, and not very much used to personal medication. Sometimes the specimen is two or three days old, which means that it was procured directly after the last consultation, so that it should not be forgotten. Hysterical women are much more apt to have liberal ideas as to quantity, probably on account of a polyuria, which furnishes a rich supply. The mother always sends a small sample of the baby's renal work. Here one can easily see the working of a logical mind, which some ignorantly deny to women. The baby being small naturally not so much of a specimen is needed. Men unquestionably take a larger and more generous view of what the doctor needs. A half-pint to a pint of morning urine seems to be considered the correct thing. Occasionally two bottles, neatly done up and carefully labelled "Morning" and "Night," are furnished as a basis for a scientific study. When a patient on calling takes from his pocket two bottles thus marked, which he has voluntarily prepared, a diagnosis of morbid introspection and chronic invalidism can at once be made.

## RAPID EATING.

In the *Journal of Nervous and Men-*



*tal Diseases*, Dr. Browning writes as follows: There is a prevalent idea that slow eating is very favorable to digestion. But this is largely fallacious. The important point is not that we eat slowly or fast, but that when we do eat we chew with energy. Of course, where the haste is due to some mental anxiety this may injuriously inhibit the secretions. Slow eating begets a habit of simply mumbling the food without really masticating it, whilst the hurried eater is inclined to swallow his food before proper mastication. Hence, hurried eating is bad, but rapid mastication is advantageous. It concentrates our energies on the act in question, and hence more thoroughly accomplishes it. Moreover, energetic chewing stimulates the secretion of saliva in the most favorable manner.

These various points are so commonly misunderstood, at least by the laity, that they demand our frequent attention.

#### MY FIRST CASE.

My first case of obstetrics was somewhat unique, and of course made a lasting impression upon me. I was not yet a graduate, but I had attended two sessions and considered myself quite skillful and scientific. My preceptor took me in charge one day, and introduced me to an old colored lady who was about to be confined. This lady carried considerable weight with her—I believe she weighed three hundred pounds—and, as the weather was very hot, the case proved to be quite interesting. I remember having read somewhere that the doctor should sit down quietly and read a book, wait for matters to develop and not be too meddlesome. I found an

old almanac, but could not read a word of it, for I had an attack of globus hystericus; and as I was trembling and gasping for breath, two colored ladies came in—one of them was Ol' Auntie Smith, who was known as a great nurse. Ah! but wasn't this an angel's visit? The patient now had strong pains, and the nurse said, "Doctah, is you gwine to try a pain?" Never having seen a case before, and not understanding, I tried to look wise and answered "Bimeby." In a short time the labor was more advanced, and the old nurse called upon me again, "Please, doctah, you better 'zamine dis yer lady." Accordingly I passed my hand somewhere in the region of the vulvæ, and suddenly there was a tremendous gush and splashing sound which almost demoralized me; still I congratulated myself upon my bravery in this supposed case of "terrible hæmorrhage," and, not wishing to alarm the bystanders by exposing my ghastly, blood-stained hand and arm, I remained petrified, as it were, in the same position. Just then the old nurse said, "Doctah, I reckon de wattahs is done broke, ain't dey?" Ye gods! what a relief this was to me. I suddenly remembered that there was such a thing as the rupture of the membranes, and, withdrawing my hand, it is needless to say I had more respect for that old nurse than for any lady I ever saw. The baby was born immediately, and, with some encouragement and instructions, I recovered myself sufficiently to tie the cord. The baby was placed in a cradle, and the nurse exclaimed, "Yo pufessional gen'lemen ginally waits 'bout a half ouah fur de afterbuf, don't you, doctah?" "Yes," said I, but, owing to the great strain

upon my nerves, the reaction had now come on and I hadn't the remotest idea of what the old nurse meant. We didn't have to wait, however, for the afterbirth came away in a minute or two, and the patient herself exclaimed, "It's done come, Auntie; it's done come." The old nurse removed the afterbirth and soiled clothing carefully, and took a nice clean band and applied it snugly around the patient. And this was the end of one of the most natural cases I ever attended. While washing my hands in an adjoining room, I overheard the old nurse saying, "Dat ar young gen'leman's a mighty fine doctah; he 'minds one of the doctahs down Souf, wen I lived in ole Virginny." These good old souls have long since passed away and crossed the river, where they are now resting under the shade trees.—Dr. Williams, *Medical Age*.

#### ARSENICAL POISONING.

In an article on "The Manufacture of Arsenic," *Chamber's Journal* says:

Arsenic as a pigment has been, and we fear still is, much used in the coloring of wall-papers—in fact, Kay's orpiment is such a valuable pigment artistically that the paper stainers can hardly do without it, if purchasers insist on having æsthetic greens and yellows. And, here, the writer desires to place on record a certain experience of his own. Some years ago he obtained from a noted firm some æsthetic papers for his house. A few years later his children were afflicted with obstinate sores about the mouth, wrists and ankles which resisted medical treatment. All at once it occurred to the writer to have the wall-papers analyzed. They were found to be charged

with arsenic; the gum fastening the pigment to the paper had yielded, and the arsenical dust was flying about and lodging everywhere. The children were removed, and recovered.

The workmen engaged in the manufacture of arsenic have their mouths and noses muffled to prevent inhalation of the dust. They wash and completely change their clothing on leaving work; and enjoy complete freedom from zymotic diseases, as all germs are killed, either by the arsenic dust or by the sulphurous acid given off in the manufacture.

The time of greatest harm from the arsenic dust is the summer, when the men sweat freely. Then the arsenic adheres to the skin and produces sores. Moreover, where there is a wound, if the arsenic enters it, it will not heal until the bone is reached. The best remedy for sores produced by arsenic is fuller's earth.

The workmen believe that the arsenic produces shortness of breath and asthma; but this is probably due to the use of the mufflers.

It is believed at these Devonshire Mines that an arsenic worker is fit for no other work. He must remain at this occupation. Health and breath fail him at other employments. Eventually, it may be said, chronic arsenical poisoning ensues; but this may be staved off, if not wholly prevented, by scrupulous cleanliness, by care taken not only to wash in the "changing-house" but to bathe freely at home.

#### GONORRHOEA IN CHILDREN.

In the *St. Louis Clinique*, July, Dr. Jacobson presents an instructive article upon this subject and gives the following suggestions in regard to treatment:

## IN THE MALE CHILD.

The gonorrhœa of male children may occur at an exceedingly early age; thus one child was infected when it was but fifteen days old. Róna reports a case fifteen months old complicated by double epididymitis. It is mostly observed between the first and seventh year. The complications are much the same as those noted in the adult; prostatitis, signs of vesical irritability, and epididymitis have all been recorded.

The inflammation is rebellious to treatment and is liable to become chronic.

Its treatment is conducted upon the general principles the application of which has given the best results in men. In the florid stage, prolonged hot baths and the administration of alkaline diuretics; as the disease subsides, the employment of mild antiseptic and astringent injections, such as nitrate of silver 1 to 8000, bichloride of mercury 1 to 12,000, carbolic acid 1 to 300, and in the later stages, fluid extract of hydrastis 1 to 30 and campho-carbodate of zinc 1 to 200. The disease in children very frequently invades the mucous membrane of the posterior urethra. In such cases it may be necessary to resort to irrigation practised by means of small rubber catheters, or to instillations into the posterior urethra. As a result of chronic urethritis strictures sometimes form, but these are exceedingly rare.

## IN THE FEMALE CHILD.

The local treatment consists in repeated irrigation of the inflamed region with warm antiseptic lotions, such as nitrate of silver 1 to 10,000, or corrosive sublimate 1 to 10,000. These irrigations should be copious and should be repeated

twice a day. The vagina may be washed out by means of a soft, small rubber catheter inserted within the orifice of the hymen. The labia are gently dusted with very finely powdered zinc oxide, and are kept from coming into contact with each other by means of pledgets of absorbent cotton. It is safe to make no direct application to the urethra at first. In the subsiding stage this canal may be flushed out by means of a very small, soft rubber catheter.

## UNUSUAL EFFECTS OF THE NITRITES.

In a Croonian Lecture on the pharmacology and therapy of the nitrites and allied compounds, Dr. Leech (*Lancet*, July 1st) says:

A decreased frequency of the pulse is sometimes seen after nitrites, but this, with small doses at least, is never considerable. After poisonous doses marked slowing of the heart has been in some cases noted. This may be due to the direct influence of the drug upon the heart. It will be remembered that nitrites render the beat of the isolated heart slow after first quickening it. Irregularity of the heart's action has been observed after the administration of nitrites, and in a few cases extreme irregularity has been reported after large doses of sodium nitrite and inhalation of amyl nitrite. Using small doses of the sodium compound, I have never seen any marked irregularity result. In two or three instances out of forty or fifty, in which the pulse has been watched carefully for many hours after sodium or ethyl nitrite, slight intermission and irregularity have occurred, which had not been recorded before the nitrite was given. Slight irregularity of the pulse is common after



the inhalation of amyl, isobutyl and propyl nitrite. On the other hand, I have met with at least four cases in which an irregular action, fairly marked before the administration of nitrites, became distinctly less or disappeared entirely when nitrites were given. I have never seen it seriously increased and I am quite sure that the irregularity of the pulse is no bar to the administration of nitrites when for other reasons they are called for.

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### Medical Items.

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Where you are in doubt as to the diagnosis, examine the urine; and where you think you know, examine the urine.

To stop the oozing of blood from bone Prof. Keen uses a paste made of carbolic acid, salicylic acid, and white purified wax.—*Ex.*

Dr. Wm. Goodell says: "Personally I cannot recall a single case in which a woman has borne a child after having suffered with gonorrhœa. Strumpets rarely become pregnant. for most of them have had this disease."—*Medical Fortnightly.*

Ichthyol is highly recommended by Dr. Damiens, subcutaneously, as an *anodyne*, particularly in cases of neuralgic pains associated with inflammatory processes which have caused exudation; in addition to the absorption of the inflammatory swelling, it effects the suppression of the pain.

Prof. E. E. Montgomery, of the Jefferson Medical College, says that in tumors of the rectum when the posterior

wall of the vagina is infiltrated to a certain degree, and its mucous membrane cannot be pushed over or moved upon the infiltration, malignant disease is to be strongly suspected.—*St. Louis Clinique.*

"Hello, Rivers! You seem to have a bad cold."

"Worst I ever had, Banks."

"I'm sorry for you, old fellow. Wish I knew of something that would cure you, but I don't."

(With tears in his eyes.) "Give me your hand, Banks! You're the only man I've seen for three days that hadn't a sure cure.—*Chi. Trib.—Ex.*

In a recent publication Dr. Galton, who has made himself famous by his study of the lines of the finger-print, reports that after fourteen years the finger-prints of certain individuals give the same ridges even under a magnifying glass. He says that the Bengal police are in the habit of taking the print of a single finger in order to identify criminals.

The Nineteenth Annual Meeting of the Mississippi Valley Medical Association will take place in Indianapolis, Wednesday, Thursday and Friday, October 4, 5 and 6, 1893. A general session will be held each morning and the afternoons will be devoted to section work. There will be three sections at this meeting, viz.: One on General Medicine, one on General Surgery, and one on Obstetrics and Gynæcology; the last mentioned having been added since the last meeting. An unusually large attendance is expected, in this the World's Fair year. Reduced railroad rates will be provided, further notice of which will be given. Frederick C. Woodburn, No. 399 College Avenue, Indianapolis, is Secretary.

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## Original Articles.

### NATURE AND TREATMENT OF DIPHTHERIA.\*

BY JOSEPH T. SMITH, M. D.,

Professor of Materia Medica and Therapeutics and  
Clinical Professor of Diseases of the Chest,  
Woman's Medical College of Baltimore.

Few medical events in this city have excited as much interest as the circumstances connected with the death of Prof. Chas. Frick, which occurred on the 25th of March, 1860. He died from direct exposure to the infective agents of a disease which then, as now, profoundly interested a profession in which he was a hard and zealous worker.

Diphtheria was then agitating the whole world, lay and medical. The preced-

ing year, 1859, it raged as an epidemic in England, and the rear guard of its destructive invasion had not disappeared in 1861. Such an opportunity for the practical study of a disease was earnestly seized, as the works of Hart, Radcliffe and Sir Wm. Jenner amply testify. For ten years previous to the great English epidemic, diphtheria was known, and through its impressive outbursts in Paris and Boulogne served to fix the attention of the profession; still it was not until about the time of Prof. Frick's death that the disease, by its spread and malignancy, furnished the material for an account of its nature and treatment such as that given by Dr. H. Greenhorn. From that time to the present diphtheria has engaged the attention of the most competent men. At this time the causative agent or agents at work in its

\*Read before the Baltimore Medical Association, March 13, 1893.

production are the subject of investigation in all our laboratories; the journals continue to teem with articles in regard to it; and the Gulstonian lecturer of 1892 took the chemical pathology of diphtheria as his text. The physician at the bedside is trying to follow out his laboratory teachings and to see how far such instructions can be made to subserve his purpose. How far we have fallen short all know, but if we have gained in the direction of prevention, it has been a great gain; for if by isolation and the destruction of the disease-bearing organism we can confine the disease, as we believe we can, great power has been given to us since the days of Jenner and Frick. The disease, as all others, has its two points of essential interest upon which any good results which we may get will depend, an early diagnosis and efficient treatment. Dr. Sidney Martin, in his Gulstonian lecture, 1892, gives us some interesting conclusions, and by a brief review we may get a very clear conception of the modern belief in so far as it relates to the causation of diphtheria. The infecting agent is a micro-organism, finding lodgment upon an exposed portion of the body, usually the mucous membrane of the throat, and known as the bacillus diphtheriæ; it finds the material for its growth in the fibrin; it remains throughout its existence upon or to a moderate depth beneath the surface upon which it originally fell. During the growth a ferment is formed; this enters the blood in part, and in part acts upon the materials (proteid) in its vicinity. From its growth, two things happen: ferment enters the blood, together with poisonous substances. The ferment formed seems to act upon the proteid

material at the seat of the growth of the bacilli, and digesting it gives rise to two new substances, albumose and an organic acid; these are the poisonous agents; they seem most virulent at the seat of growth of the bacilli. The poison thus formed enters the blood with the ferment; this unused ferment will act upon the proteid materials elsewhere and give rise thus to fresh poisonous material in the body. Thus in the spleen, where the blood flows slowly and is at times almost stagnant, the ferment will digest the proteid material there met with; and so it comes to pass that the spleen will become a centre for the production of the poison, with the difference that it (the poison) is not of so virulent a character. Examinations show that the albumoses continue in the blood some time after the acute disease is over, and thus some explain the existence of the late paralysis. The albumoses found in the tissues of those dead from diphtheria gave rise, when inoculated into rabbits, to local œdema, fever, paresis of muscles, and loss of weight, and diarrhœa.

Dr. Martin compared the conditions in diphtheria with those in anthrax, infective endocarditis and tetanus, and found that if the bacilli of these diseases were grown in a medium similar to that of the fluid of the body, they would digest and form poisonous products as the result of that digestion; and that there seemed to be a strong resemblance between these diseases and diphtheria; only in anthrax and infective endocarditis the bacilli enter the body and directly attack the proteids, while in diphtheria the proteids are attacked directly, not by the bacilli, but by the ferment. It would



thus appear that our original belief in the direct action of the bacilli is to be done away with and in its stead we take up the belief that these grow only upon their original seat, and that as they develop a ferment is formed which in turn alters and forms from the proteids poisonous agents, these in their turn producing the condition known as diphtheria. A long chain before the result is reached. If any link in this chain can be broken the result could not be attained, therefore we may be able at some future time to attack and destroy the ferment; or the albuminoses if we cannot, as does not at present seem probable, use our disinfectants of sufficient power to destroy the bacilli where they seem so easy of access. We have in all this a comparatively simple form of digestion to deal with, which, if we can stop at any point, will give us that controlling power over the disease we are looking for.

Having apparently opened up the way to a clearer understanding of the disease, the next most important subject for investigation is how shall we know the disease in the early stages and how much can we learn from the local investigations.

It was thought at one time that we had the key to the whole subject by the attachment or loose attachment of the membrane to the tissues beneath, but we are not able to thus determine whether a bleeding surface after the removal of the membrane would show the condition to be due to diphtheria or not.

Since 1883, and especially since 1884, when the two noted investigators, confirming and strengthening each other's

conclusions, gave the name of the Klebs-Loeffler bacillus to an organism which was believed to be the direct cause of the disease, the medical world looked forward with hope to an early settlement of the question of diagnosis.

When, however, more light was thrown upon the subject, many new difficulties were discovered. The appearance of the membrane cannot be followed as a safe guide. "Extensive thin, grayish pseudo-membranes, occurring only on those surfaces of the uvula, tonsils and faucial pillars which lie in contact," may be looked upon as present in those cases of pseudo-diphtheria; while "the thick, grayish-yellow pseudo-membranes which cover a large portion of the soft palate and tonsils, often involving naso-pharynx and nostrils," may be looked upon as true diphtheria; still we are not always able to so distinguish them, and in cases where but little membrane shows itself at the time we need to make our diagnosis, the distinction is not to be made at all. I recall a little patient, and you have all had such, whom I found with a light, thin membrane covering part of the left tonsil and faucial pillars; slight, thin, well-marked, I know not what it was, but two days cleared it away and the boy was well.

Turning from this view of the question to the organism itself, can we learn anything from that to help us out of our great difficulty?

It may be remarked that even if we find here a safe guide, the instruments needed, the time, care and the required skill, will prevent its being availed of by any except those in charge of the hospitals with well-equipped laboratories attached, or those who live in large cities

with more or less leisure at their command.

This special view of the subject can not be entered upon without the mention of and information gained from the prize essay of Dr. Wm. H. Park, who has made many elaborate clinical and bacteriological experiments in this direction.

Two organisms appear to be concerned in the production of pseudo-membrane inflammations, the streptococcus and the Loeffler bacillus; they grow and flourish together; some membranes will show one variety in excess, others the other. The result of examinations, then, show the presence of organisms different the one from the other, yet both giving rise to throat conditions which only the microscope, skilfully handled, can determine. Thus the streptococci are often present in the throat, and only wait conditions favorable for their growth to produce inflammations; while on the other hand the bacillus of diphtheria is a specific organism giving rise to its own train of diseased conditions.

To quote from the author just referred to "the first (Loeffler bacillus) is from beginning to end a local process, and its lesions are due to the effects of the poison formed by the bacilli in the pseudo-membrane. It is dangerous at all periods of life. The second (some form of streptococcus) is also at first a local lesion, but may at any time become a general infection. These two diseases caused by different bacteriæ and differing in so many points should no longer be called by the same name."

It does not come within the scope of

this paper to give a detailed description of the Loeffler-bacilli and streptococci and their activities; but to show that there are pseudo-membranous inflammations which are not to be classed as diphtheria, and to be able to distinguish the true from the false. At present the diagnosis would seem to rest upon the finding of the specific organism.

One of two conditions must prevail if the physician at the bed-side and in his daily round of work is to have a ready means of diagnosis: either the culture methods, etc., must be greatly simplified, or we must look in other directions for a solution of that most vexed problem, the early diagnosis of diphtheria. It would be out of place here to enumerate even in brief the opinions in regard to croup and diphtheria. You are familiar with the many arguments, pro and con, which have been advanced. Needless to say here that until recently membranous croup and diphtheria had come to be regarded as one and the same by a majority of those most competent to judge, or at least we know no way to distinguish them. Professor Bajinsky has, however, once more opened up the subject, and as the result of his observations, clinical and bacteriological, we are to look upon the subject as still unsettled. As a result of his observations, it is likely there are two distinct forms of pseudo-membrane in the larynx, associated with different organisms; one of these is a true diphtheria and the Loeffler bacillus is to be found; the other is not so, but is associated with staphylococci and streptococci. The former is much more dangerous than the latter, being more se-

vere in its manifestations and being more contagious.

As with so many of the pseudo-membranes which show themselves upon the throat, a diagnosis can only be made, if made at all, by the microscope, so we find in the larynx. If this is true, while clinically we may not be able to make a clear diagnosis, if we know that in a certain proportion of cases some are not diphtheria we will institute one treatment and can look forward to a good result with a certain measure of hope.

Upon the tonsils, uvula, pillars of the fauces, pharynx and larynx pseudo-membranes may show themselves, either alone or in connection with diseased conditions, such as scarlet fever, measles, etc., and we are called upon for a diagnosis; can it be made?

From a clinical standpoint the answer would seem to be, No; from that of microscopes, Yes.

As regards treatment, we have not found anything up to this time to change the views we expressed in a paper we had the honor to read before the State Faculty in April, 1891, and published in its transactions for that year.

In regard to isolation and disinfection, if we are to be on the safe side, all cases are to be subjected to both at once; as it will take a day under the most favorable circumstances to obtain any result from the microscope. We seem, then, as the result of our present knowledge of diphtheria, to be able to explain in a more satisfactory way than ever before the great diversity of opinion in regard to the treatment of diphtheria. If it is true that we have two diseased conditions to deal with, which can only be distinguished in the laboratory, we have an explanation

of the results brought about by different modes of treatment and the confident assertions so often made of the great value of special drugs or of special modes of treatment.

If emphasis has been given to any special drug it is the bichloride of mercury. Dr. Park speaks highly of the irrigation of the throat and nose with a 1 to 4,000 solution and says no poisonous symptoms were met with even in those cases where irrigation was employed every half hour.

1010 Madison Ave.

# ENTERECTOMY FOR OBSTRUCTIVE EPITHELIOMA AT THE ILEO-CÆCAL VALVE; SECONDARY ANASTOMOSIS OPERATION BY ABBE'S LONG INCISION.

BY JAMES M. BARTON, A. M., M. D.,  
Surgeon to the Jefferson College Hospital and to the Philadelphia Hospital.

I saw Mr. B. for the first time, on April 18, 1892, at Millville, N. J., in consultation with Drs. Smith and Newell. He was in bed, was very pale and thin, and had frequent attacks of sharp pain while we were talking to him. I obtained the following history. He was twenty-seven years of age, and had been in his usual health until the first of January, when he had an attack, similar to the present one, lasting one week. From then until the latter part of March he was able to attend to his work in the glass house, but was troubled with some pain and considerable tenesmus. He went to the water closet from four to eight times daily, passing, with difficulty,



a few small scybala each time. His constipation increased until four weeks ago he had several attacks of complete obstruction, each lasting four or five days, and only relieved after taking many purgatives.

He now has and has had for the last two weeks about four diarrhœic passages daily. He has severe attacks of cramp in the right iliac fossa every few minutes, requiring the constant use of large doses of morphia. These attacks are accompanied by a half-inch elevation of the abdominal walls over the painful point. As the pain leaves, the abdominal wall descends, and gurgling of wind is heard and felt. He has been confined to bed for two weeks and is greatly exhausted. There is no elevation of temperature, no tenderness on pressure, and there is no tumor felt, though carefully searched for. There has been no vomiting at any time.

From the absence of vomiting and the marked tenesmus present, I regarded the obstruction as being in or near to the beginning of the large bowel; that it was not far from the ileo-cæcal valve was shown by the elevation of the abdominal wall at this point by the obstructed gas. The diarrhœa was an evidence of an intussusception, and the very short time the symptoms had existed, and the very complete obstruction present, pointed to a malignant growth as the cause of the intussusception.

Two days later I again visited Millville for the purpose of removing the growth. I was assisted by Drs. Newell and Smith, of Millville, Dr. Jones, of Camden, and Mr. Borsch, a student at Jefferson College. An incision about three inches long was made in the right

iliac fossa, similar to the incision made in removing the appendix. On introducing the finger the growth was found at once. The intussusception could not be reduced, as the epithelioma had grown since it had occurred. After incising the bowel to verify the diagnosis, I removed about six inches of the intestine, including the obstructing epithelioma. Preparations had been made to perform lateral anastomosis at once, but the patient was so severely shocked that the operation was terminated by a temporary artificial anus.

He recovered without difficulty, rapidly gaining flesh and strength, and came to me, in Philadelphia, in June, to have the anastomosis operation performed. I placed him in a private room in the Jefferson College Hospital, and on the 16th I operated, assisted by Drs. Ashton, Fisher, Mr. Borsch, and the house staff. My purpose was to make a long opening, by the method devised by Dr. Abbe, between the lowest possible portion of the ileum and the highest and most convenient portion of the colon; to permit the artificial anus to remain as a safety valve and only close it after the anastomosis opening worked satisfactorily. In order to determine where to make my incision, I probed the bowel at the artificial anus, some days before the operation, with various sounds and catheters, and found it ran directly across the abdomen to the left iliac fossa. As I could not hope to join this to the ascending colon, I decided to use either the transverse colon or the sigmoid flexure, and to open the abdomen by a short incision to the left of the left rectus, as being within reach of both these portions of the large bowel and directly over the portion of the small

bowel I wished to use, but far enough from the artificial anus to escape the risk of infection. This was an error; the incision should have been made in the median line, rather higher than I did make it and long enough to get a fair view of the intestines.

Just before opening the abdomen I introduced a sound into the artificial anus, so that I might be able to verify, without delay, the portion of the ileum I wished to use after the abdomen was opened.

A three-inch incision was made about two inches to the left of the median line and parallel with it, ending just above Poupart's ligament. The ileum, with the bougie in it, was readily identified, and as the transverse colon hung well into the wound, the sigmoid flexure was not searched for. After stripping the portions of the bowel I intended to use of their contents, and preventing their return by a temporary rubber ligature, the ileum and colon were laid side by side and joined by a line of suture five inches long; when completed the needle was removed and the unused thread permitted to remain. A second line of suture, four and a half inches long, parallel and close to the first, was introduced, and the unused threads were also permitted to remain.

Both bowels were then opened by a four-inch incision about a quarter of an inch from the last suture. A third suture was used to join the edges together, passing each stitch across the freshly divided edges so as to check the bleeding. This stitch is known among seamstresses as a "whipping stitch." The pliability of the intestines is such that not only the distal edge can be so closed, but a

large portion of the edge on the side of the incision toward the operator. A needle was now placed on the unused thread attached to the second line of suture, and this was continued around the ends and in front of the opening, joining the intestines together at about a quarter of an inch from the opening and parallel to it. This suture, when completed, entirely surrounds the opening, and is about a quarter of an inch from it. Lastly, the unused thread of the first suture, which was still hanging at the end, has a needle put on it, and it is carried around the ends and in front of the opening. This suture when completed also surrounds the opening and is about half an inch from it.

The operation can be quite rapidly performed, the intestines being held in contact by an assistant. After the first line of stitching is made it is still easier, and the suture can be made nearly as fast as the same operator would sew a seam in muslin.

The whole operation was performed with a constant stream of tepid boiled water flowing over the intestines we were joining together. As soon as the stitching was completed the intestines were replaced in the abdominal cavity, which was thoroughly flushed, and as the sutured intestines laid in position without undue strain, the abdomen was closed.

The slight vomiting after the ether soon ceased. A number of ounces of fecal matter passed from the artificial anus, but less than before the operation. At the expiration of twenty four hours there was occasional regurgitation of fluid from the stomach, and when I saw him at 8 o'clock on the second morning the regurgitated fluids had become coffee-

colored. An hour later, forty-three hours after the last operation, I reopened the wound, but failed to find the cause of the obstruction. The sutured intestines lay quite stiffly in place, being kept so by the numerous lines of sutures and the resulting plastic deposit, the small intestine was rather sharply flexed at the extremity, but not enough to obstruct. After as full a search as the condition of the patient warranted, it was concluded that the obstruction must be at the sutured portion. A loop of the ileum above the anastomosis was therefore drawn into the wound and another artificial anus made, but the obstruction was unrelieved, neither gas nor fecal matters passed, and the patient died forty-eight hours later, or four days after the operation.

At the post-mortem there was no evidence of recent peritonitis anywhere, the cause of all the difficulty being an old adhesion of the ileum to the abdominal wall at the left iliac fossa. Trailing the ileum up from the original artificial anus in the right iliac fossa, it ran directly across the abdomen to the point of attachment in the left iliac fossa, making a tense band; it then ran downward, and six feet were in the pelvis. I had drawn about two feet of these six under the band and used them for the anastomosis operation. The remaining four feet, still in the pelvis, were sloughing, the circulation being entirely shut off by the band. All the parts above the band, including the intestines used in the anastomosis operation, were in admirable condition. The immediate cause of the obstruction was the increased tension of the band, produced by pulling another loop of intestine under

it at the operation. This band would probably have given trouble even if the anastomosis operation had not been performed.

The result in this case has not made me feel dissatisfied with the operation. I still think that it is the only tried method of obtaining a sufficiently large opening between intestines. Any smaller opening, no matter how made or with what devices, will be apt to contract and obstruct.

The Abbé operation can be quite rapidly performed. In the case above narrated, the patient suffered from no appreciable shock, though he had but recently recovered from a nearly fatal illness.

In performing this operation again I should make the incision in the median line, and make it higher and longer, so that I might not only see the condition of the intestines, find any abnormal adhesions, but before joining the intestines I should place them in position in the abdominal cavity so that they might lie without strain or tension. The intestines when joined by six lines of sutures are as unyielding as if there were a piece of card-board between them five inches long. If the intestine does not lie easily in its new position, the bowel at one end or the other of the stiffened portion may be so sharply flexed upon itself as to cause obstruction. In addition, from the same cause, there may be unnecessary strain upon the sutures.

The sutures in the above case were severely tested, the transverse colon was pulled upward by the gastro-coelic omentum, while the ileum, a few inches below the suture, was fast anchored by the adhesion. This strain was greatly



increased by the subsequent abdominal distention and frequent vomiting. But as the specimen, which I here exhibit, shows, it held perfectly.

The specimen removed at the enterectomy shows almost complete obstruction, the opening that remains being less than a quarter of an inch in diameter.

### Society Reports.

#### CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD APRIL 21, 1893.

The 280th regular meeting was called to order by the President, Dr. William E. Moseley.

*Dr. Wm. T. Howard* exhibited specimens from TWO CASES OF GENITAL TUBERCULOSIS. In the first case the primary seat of the disease was evidently in the left ovary and tube, which could not be found, but were represented by a large pus sac. There were tubercles everywhere over the structures in the peritoneal cavity. The lungs were the seat of acute miliary tuberculosis of the pleuræ. The retro-peritoneal lymphatic glands were very much enlarged, some of them as large as a lemon. The glands in the mediastinum were enlarged and caseous. The lungs were affected through the chain of lymphatic glands leading up from the pelvis. The second case was one of primary tuberculosis of the kidneys. A white man, aged 34 years, who died of uræmia 34 hours after entrance to St. Joseph's Hospital. His lungs and pleuræ were the seat of acute miliary tuberculosis. Peritoneal cavity negative and contained no fluid. Right kidney a good deal smaller than normal and quite

irregular in outline. Capsule densely adherent. On section were found great numbers of more or less triangular cysts or spaces, with bases on the cortex, filled for the most part with thick putty like material easily removed by the fingers. The cortex of the kidney had almost entirely disappeared. The pelvis of the kidney was roughened and covered with fibrinous material. Ureter had same appearance. The lumen of the ureter was open for about one-half its length and the ureter was simply a fibrous band. Left kidney very much larger than the right and larger than normal. Inner side of capsule covered with masses of thick caseous pus. On section: cortex pale and increased in thickness. Medullary portion in great part lost. About the centre of each pyramid of the kidney is a large abscess cavity containing a thick caseous pus. Pelvis of kidney is studded with miliary tubercles and in places dense fibrinous pseudo-membrane. Ureter on left side dilated and covered with dense pseudo-membrane. The same pseudo-membrane was present in the bladder. The mouth of the right ureter was completely closed. On the the left side of the bladder the mucous membrane was deeply hæmorrhagic. At the neck of the bladder and throughout the whole of the urethra the mucous membrane was the seat of the same pseudo-membranous formation. The pelvis of the kidney, the ureter and bladder were filled with thick caseous pus. Left epididymis, left testicle and left vas deferens were all tuberculous.

The pus from the urethra and bladder showed three interesting things. First, there were great numbers of tubercle bacilli, singly and in masses. Second,

large numbers of diplococci which might be very readily mistaken for gonococci. Third, a large number of a long bacillus, much longer than the tubercle bacillus. It is not known what this bacillus is, but it is frequently found in cases of suppuration of the genito-urinary tract in males. Perhaps the most interesting point is the thick pseudo-membrane formation in the pelvis of the kidney, the ureter, bladder and urethra. It is nearly all composed of fibrin in which are innumerable bacilli of the kinds mentioned.

*Dr. J. W. Williams* thought there was little doubt but that the tuberculous process originated in the ovary and tube in *Dr. Howard's* first case. He has made careful microscopical examinations of many tubes and ovaries removed for various causes and has found that genital tuberculosis in women is far more frequent than has been supposed. While a certain number of cases from macroscopic appearances at operation are diagnosed as tuberculosis, yet there are probably three times as many cases of tuberculosis where there is no suspicion from macroscopic appearance. In the male we have a combination of genito-urinary tuberculosis. Genito-urinary tuberculosis, owing to anatomical conditions, is not nearly so frequent in the female.

*Dr. J. M. Hundley* read a paper on CAUSE AND CURE OF ENDOMETRITIS. Those cases of endometritis which are not the result of septic, gonorrhœal or puerperal processes but which come from over-fatigue, taking cold, undue violence in coition and over-indulgence, are best treated by rest in bed, sedatives, poultices over the uterus, and possibly vaginal douches if they give relief. Of the

chronic cases, there is a class characterized by a milky, non-irritating discharge caused by debility, sedentary habits, versions, flexions, etc. These are easily cured, but we should always bear in mind that these mild cases can be easily converted into septic ones. *Dr. Hundley* had seen two cases of tubal and ovarian disease the result of intrauterine medication. He does not now make use of the sound to make diagnoses in dispensary work. Intrauterine applications as ordinarily made are of no value and are dangerous. In the septic cases, which are characterized by a muco-purulent secretion, he does not attempt to treat the uterine mucous membrane by applications. By dilatation, curettement and packing with iodoform gauze a cure is usually effected in about six weeks. This treatment is used irrespective of existing complications. The only effective way to effectually apply medicaments to the endometrium is to first scrape away all the secretions with a blunt curette and then make the applications with a glass pipette, as recommended by *Skene*; or a cotton-wrapped applicator, and then use boroglyceride tampons. Cases treated in this way will get well, but it takes months of treatment. *Dr. Hundley* treats all these cases by dilatation, curettement and packing.

*Dr. W. P. Chunn* was pleased to hear *Dr. Hundley* say that many of the cases of chronic endometritis were now cured in six weeks. He had heard *Dr. Simms* say about ten years ago that he had a great deal of trouble in curing endometritis and it took a year and perhaps two years.

*Dr. Hundley* properly recommends dilatation in the very beginning of treat-

ment as in that way medicaments could be applied to the parts affected. It is often hard to cure even under these circumstances, for where there is drainage from the Fallopian tubes it may keep up the trouble.

Dr. J. H. Branham said that a certain school has been decrying almost every effort at treating the uterus or doing anything else in gynaecology except laparotomies, and call all these efforts "gynaecological tinkering" and say it does more harm than good. The recognition of the fact that it is important to treat intra-uterine conditions with careful antiseptic precautions, and that endometritis is a septic condition needing cleansing and drainage, will give better results in future in the treatment of these cases. If cases of chronic endometritis are cured, then secondary infections that otherwise might occur are prevented. After the uterus is dilated then we can use antiseptic applications with benefit and without danger.

Dr. Wm. E. Moseley said that the modern method of treating endometritis was a development which has been going on for the last twelve years. The first case he was aware of to be treated by washing out the uterus was in the Woman's Hospital, New York, in 1880, when he was on the staff of Dr. Charles Lee. Dr. Moseley washed out the uterus under Dr. Lee's direction with weak carbolic solution. This was repeated once. Something like a gallon of water was used each time. She improved very much. Dr. Emmet was averse to any application to the interior of the uterus. The result of Dr. Lee's case was so satisfactory that Dr. Emmet had Dr. Moseley try it on one of his own patients,

with good results. Dr. Moseley continued this treatment in his practice, gradually adopting the methods of curetting and more lately drainage. In many cases of chronic endometritis there is comparatively little need of dilatation. The more chronic the case the more open the cervical canal, and a suitable curette can as a rule be pretty easily passed. Washing out the uterus has been routine practice in hospital work for the last dozen years and he has never seen any harm from it when done either with a double current catheter or in case the canal is large enough, with a single catheter. After curetting, if there is no temperature, the patient is allowed to get out of bed in four to six days.

W. T. WATSON, M. D., Sec'y.

1519 N. Broadway.

#### DO THE SICK SNEEZE?

"Do those who are seriously ill ever sneeze?" This is a point alluded to by Mr. Jonathan Hutchinson in the January number of his *Archives*. He does not recollect himself to have seen any but fairly healthy persons sneeze. He puts the question with especial reference to the widely spread popular superstition that sneezing is a sign of health and good luck. It is possible, he thinks, that this may have had its origin in the fact that it is for the most part an act restricted to those in fair health. Tylor, in his "Primitive Culture," gives interesting facts as to the prevalence of this creed and as to certain customs associated with it, and traces it in part to doctrines of animism, but Mr. Hutchinson thinks the suggestion he has given may also have some value.—*Sheffield Med. Jour.*—*Ex.*



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BALTIMORE, AUGUST 12, 1893.

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**Editorial.**

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**THE WOMAN'S MEDICAL COLLEGE.**

The question has been asked us recently—"How will the Woman's Medical College of Baltimore be affected by the opening of the Johns Hopkins Medical School to both sexes?"

In response we are pleased to inform enquirers that the Woman's Medical College, which has for twelve years been educating women for the professional career, is giving evidence of renewed vigor.

A few days ago we had the pleasure through the courtesy of one of its professors of visiting its new college home on the corner of McCulloh and Hoffman Streets, opposite the Good Samaritan Hospital (the hospital connected with the college).

This college building is in every way more attractive, convenient and commodious than that occupied last year; having large, attractive lecture rooms, with

laboratories and dispensary departments, as demanded by modern progress. The college has adopted the three-year graded course of instruction, and has made great sacrifices for the sake of high standards of graduation. It is believed that the enlightened policy of its faculty and the growing fame of Baltimore as a centre of medical education will secure the steady growth of this college in the future as in the past.

The faculty of the college is at present as follows:

Drs. B. B. Browne, Prof. Diseases of Women; Thos A. Ashby, Prof. Obstetrics and Clinical Gynæcology; Eugene F. Cordell, Prof. Principles and Practice of Medicine; John G. Jay, Prof. Principles and Practice of Surgery; Amanda Taylor-Norris, Prof. Practical Obstetrics; Hiram Woods, Jr., Prof. Diseases of Eye and Ear; Joseph T. Smith, Dean, 1010 Madison Ave., Prof. Materia Medica and Therapeutics, and Clinical Prof. Diseases of Chest; John R. Winslow, Prof. Physiology, and Clinical Prof. Diseases of Throat and Nose; I. R. Trimble, Prof. Anatomy and Clinical Surgery; Charles W. Mitchell, Prof. Diseases of Children; Pearce Kintzing, Prof. of Chemistry; Henry P. Hynson, Ph. G., Lecturer on Pharmacy; J. D. Farrar, M. D., Lecturer on Pathology and Histology; Claribel Cone, M. D., Lecturer on Hygiene; Julian Stuart Jones, LL.B., Lecturer on Medical Jurisprudence; T. Brice Marden, M. D., Demonstrator of Anatomy and Chemistry.

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On account of the presence of cholera in Italy, the meeting of the International Medical Congress has been postponed until April, 1894.

## STRONTIUM BROMIDE IN CHRONIC EPILEPSY.

For some time we have received notices from a manufacturing firm that they were furnishing strontium bromide (Paraf-Javal) in a very pure form, and that with this new preparation of the drug valuable therapeutic results in nervous diseases were being obtained by certain foreign observers.

It is with pleasure therefore that we have received from our friend, Dr. Henry J. Berkley, Lecturer on Psychiatry in the Johns Hopkins Medical School, and well-known to us as a careful and impartial observer, a pamphlet (reprinted from the *Johns Hopkins Hospital Bulletin*, for May) containing an extensive clinical study of the above preparation in the wards of the Baltimore City Insane Asylum.

The number of patients treated was 38. The preparation used was the solution furnished by Messrs. Fougere, of New York. The dose administered was about 22 grains of strontium bromide three times a day.

Several brief histories of patients are given in the article, sufficient to show the very severe and persistent forms of disease treated by the new drug. The patients had been on the house mixture for epileptics, which contained sodium bromide, grs. xx, potass. iodide, grs. xv, in each dose, and were receiving this three times a day. This treatment was continued for several weeks in order that the number and character of the attacks under it might be noted. The patients were then put for ten days on a course of sodium chloride, grs. x, three times a day. After this the strontium bromide was regularly administered.

At the end of 5 months of observation Dr. Berkley reports that "Strontium bromide has at this date been used with 38 epileptics in the asylum, and the results obtained have been better than with all the other bromides. Cases where it has been in use for five months show no inclination to an increase of the seizures, nor a falling back to somnolent or quarrelsome states."

This would seem to confirm the suspicion held by many observers that the continued use of potassium and sodium bromides gravely affects the mental processes of the epileptic. If strontium bromide gives with other observers as favorable results as with Dr. Berkley, controlling somewhat the tendency to convulsive attacks and not stupefying the patient or making him ill-tempered, it will be a great blessing to humanity.

If such results as Dr. Berkley reports can be obtained in an almshouse run by the "practical politicians" of a large city like Baltimore on strictly "practical" lines (the editor was once resident physician in this almshouse, and knows the baneful meaning of such words), what may not be accomplished by the remedy in a well-kept, well-officered hospital, with wholesome surroundings, pleasant recreation, careful diet, and intelligent nursing?

We are informed that several leading manufacturers in our own country are prepared to furnish the bromide of strontium in a pure form.

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## Medical Progress.

### THROMBOSIS.

Writing on Venous Thrombosis in Phthisis, Dr. Dodwell gives (*Amer. Jour.*

*Med. Sci.*, June) the following treatment:

On the first indication of the super-vention of thrombosis, absolute rest of the affected member should be strictly enjoined and, as far as possible, maintained. In moving and raising the patient in bed, when necessary, care should be taken to manipulate as little as possible the situation of the obstructed veins. These precautions are to be observed with the view of diminishing, as much as possible, the risk of detachment of fragments of clot. Gentle constant support, in the form of a bandage over cotton-wool from the toes upward, will give relief and aid in checking the œdema, and at the same time will help to keep the limb warm. Where there is much pain over a vein, nothing is so good as painting the skin with glycerin and belladonna, and applying over this hot flannel fomentations; as a rule, this gives almost immediate relief and opiates are seldom required. Sleep may be interfered with, but the indications and contra-indications for hypnotics are part of the general treatment of phthisis. It will probably be found advisable in all cases, whether there be pain or not, to apply heat in the form of fomentations, which should not be too thick or heavy, as by this means the superficial vessels are dilated and collateral circulation assisted.

#### NEURALGIA FROM OBSCURE TOOTH DISEASE.

Reference has already been made to diseases of the teeth as the cause of facial neuralgia. Teeth that are perfectly sound so far as decay is concerned may be the source of pain which no amount of medication will relieve. Small, cal-

careous nodules sometimes form in the pulp, inducing pulpitis, and are more common than medical men are apt to suppose. Then, too, cases of exostosed roots and imbedded teeth are by no means rare and are a prolific source of facial neuralgia. While it is true that decayed teeth are the most common cause of this malady, the mere fact that none of the teeth present cavities of decay does not, by any means, exclude them from being the possible cause of the patients' discomfort.—Dr. Hipple, *Omaha Clinic*.

#### FOR NEURALGIA AND MYALGIA.

Dr. J. M. H. Rowland, Resident Physician at the Maryland General Hospital, informs us that the following local application is an exceedingly efficient agent for the relief of the above-named troubles:

R.—Chloroform,

Tinct. Aconit.,

Ext. Belladonna fl . āā f3ss,

Aq. Ammonia . f 3j,

Liniment Saponis . q.s. ad f3viii.

M. Sig. Use as a liniment.

#### CAUTIONARY FACTS.

1. Drugs by the rectum or vagina should be given in three times the dose by the mouth.
2. Drugs by the hypodermic method should be given in one-sixth the dose by the mouth.
3. Be cautious in giving atropia to flaxen-haired, light-complexioned, nervous women.
4. Be cautious in the use of morphia subcutaneously after opiates or morphia have been given by the mouth or rectum.
5. Chloral hydrate should be exhibited with great care.
6. Remember that children are espe-



cially susceptible to the narcotic action of opium and its alkaloids.—*Dr. King's Medical Prescriptions.*

#### A CURE FOR DESPERATE CASES OF UTERINE HÆMORRHAGE.

In the *Lancet*, June 3, Dr. James Braithwaite presents a heroic, but, in his hands, successful method of treating such cases by the intra-uterine application of chloride of zinc. He describes as follows its application in a case where perchloride of iron and fuming nitric acid failed to check the bleeding: In spite of the use of perchloride of iron again and subsequently fuming nitric acid applied to the uterine cavity, a daily hæmorrhage continued. I felt completely defeated and contemplated hysterectomy; knowing, however, the powers of chloride of zinc from constantly using it in the treatment of cancer, it occurred to me to apply this to the uterine cavity, with the view of causing a slough of the interior and so completely obliterating it. I therefore, after dilating the cervical canal once more, applied to the whole interior cotton wool wetted with the thickish fluid resulting from deliquescence of the sticks of solid chloride. This was wound round a piece of iron wire slightly curved at the end. The length of the cavity was first measured and the wool and chloride adapted accordingly, but the fluid was more sparingly spread on the wool at the proximal end, and it was so applied that it could not run off and overflow. The wire with its burden of wool was left *in situ* for twenty-four hours and then withdrawn. In the course of a fortnight a slough of the whole interior of the uterus came away about a quarter of an inch thick. The cavity became after

this completely obliterated and the uterus correspondingly smaller and more shrunken in size. This of course cured the hæmorrhage, for there was no longer any place to bleed from. The patient was discharged very much improved in health. As she had already undergone oöphorectomy, the loss of the uterine cavity was of no importance, but I can easily see how different the case would have been if the ovaries had been still active and intact.

On reflecting upon this case it seemed to me that we might produce an action short of obliteration of the cavity by the use of this remedy and consisting of merely a superficial removal of the surface to a very slight extent, in cases of a desperate character in which other remedies failed.

In another case the uterus was freely curetted after dilatation. Nothing was removable except by such forcible pressure as to scrape away the mucous membrane itself. The organ was not materially enlarged, the sound passing two and three-quarter inches. The finger exploring the cavity detected nothing and bimanually no irregularity of outline or indication of fibroid could be detected. Chloride of zinc was applied to the interior for a few minutes, but the effect was found to be transient and ineffectual. Ultimately, on February 21st last, the zinc was used with the object of destroying the interior and producing atresia. On April 14th, I received a letter from Mr. Pickles to say that he found the interior of the organ quite closed. The patient was much better in consequence of the cessation of the hæmorrhage. I have had a number of cases in which the zinc has been applied for a

few minutes only, but although a powerful styptic I have found it not permanently successful. It must either be used to produce atresia or not at all. Of course cases of such intractable hæmorrhage as to require such a remedy are very rare, and the remedy is, to a certain extent, an empirical one. It can only be applicable when a cause sufficient to explain the hæmorrhage cannot be found, and when the latter becomes dangerous to life. Still there are such cases, and there are a certain number on record in which the uterus has been removed entire after failure of all other treatment. The effect of atresia on the uterine cavity may be expected to be very different from that of removal of the uterine appendages. In the latter case the menopause is artificially induced and consequently the system produces a less amount of blood than before the operation. When; however, the ovaries are not interfered with—as in the zinc treatment—the formation of blood continues undisturbed, and consequently it is more suitable when the system is exhausted by hæmorrhage. When a woman has bled beyond a certain amount she never recovers it completely, but remains anæmic and more or less an invalid for life. This plan of treatment affords a means of recovering the loss, for the formation of blood will continue as before. It is very important to use the thick fluid only which results from the deliquescence of the sticks; and it must have recently deliquesced, otherwise much of the zinc will be deposited and lost as carbonate. It is very liable to run over and into the vagina, and if so will produce a slough. To avoid this, a plug of cotton wool containing vaseline

and carbonate of soda should be applied at the summit of the vagina; this quite neutralizes any excess. Finally, I may say that in this treatment we have a resource—an ultimate resource—after the failure of everything else except hysterectomy; safe in application and effectual in accomplishing its end, but in itself undesirable and to be avoided unless life and health are very seriously threatened.

#### POISONING BY PRIMULA OBCONICA.

On Jan. 28th I was sent for to see a man aged seventy-five. He was suffering from erysipelas, slight in character and affecting only the upper part of the face. After the usual treatment this subsided and in a little while I allowed the patient to go into his greenhouses (he was a market gardener), whereupon the disease immediately reappeared. This having occurred several times, I advised him to remain in the house for a longer period, but even then he had two attacks, the last occurring without his leaving his bedroom. In all, there were six relapses, the parts affected being the forehead, just above the eyebrows, the cheeks and sides of the nose and the fingers of both hands. At first I supposed the fresh attacks to be the result of renewed chill, but in the case of the last two, and especially the last, this cause was precluded. The patient now informed me that on these two occasions he had had flowers brought to him in the house to work into wreaths, and on further investigation I found that previously to each of the six attacks he had been working with the blossoms of the *primula obconica*, a small white or pale lilac *primula*, much used in funeral wreaths. I advised him to avoid this plant, and he did so for about three



months; but during the past week he again used it, with the result that the inflammation immediately reappeared in the skin of his fingers. The following points in this case may be of interest. The patient, who had been a gardener most of his life, had never suffered any inconvenience from handling this plant until after the attack of January (which appears undoubtedly to have been erysipelas, as his son, who never touches the flowers, had also a sharp attack of erysipelas of the face). In the secondary attacks the parts affected were those which a man would naturally wipe with his fingers when heated, and with which, therefore, the juice of the plants he was handling would be brought into contact. The attacks occurred always after he had used this particular flower, and only then. The plant is known amongst gardeners to affect certain individuals, but this patient appears to have been rendered susceptible to it by the attack of erysipelas.—Dr. Pooley, *Lancet*.

#### TORSION OF THE SPERMATIC CORD.

As this is a condition likely to be overlooked or mistaken for other troubles it is desirable that the attention of our readers should be repeatedly drawn to it. We therefore quote a case reported by Dr. Brazil in the *British Medical Journal*, July 1st. He says: The patient is a man of about 31, who, while I was attending him for another ailment, mentioned that about ten years ago he had "strained himself" in lifting a heavy weight. At the time he felt severe drawing pain in the left testicle, and soon afterwards noticed enlarged veins in its vicinity. He continued to suffer some pain in the organ, but took little

notice of it until about a month after the accident, when, finding that the varicocele was enlarging, he consulted a doctor, who gave him a lotion and recommended a suspensory bandage.

The condition at the present time is as follows: The left testis is smaller than the right, is fully descended, but obviously displaced. The epididymis is in front, and the cord can be felt to arise from its upper instead of from its lower border. In front of the testis is a large mass of varicose veins. He wears a suspensory bandage, and suffers no pain or inconvenience.

No explanation appears to have been offered as yet of the manner in which the displacement of the testis is brought about. In Mr. Nash's two cases, and in the present one, the immediate cause appears to have been a muscular strain. Possibly the sudden drawing up of the testis during a severe strain may, owing to the peculiar insertion of the cord into the lower border of the epididymis, cause the organ to revolve on its axis.

#### DECALCIFIED MILK.

In the *Lancet*, July 22, Dr. Wright presents these original ideas:

Before Arthus and Pagès discovered that blood could be deprived of its coagulability by receiving it into solutions of oxalates and fluorides, they had already discovered that milk in which the lime salts had been precipitated by these same additions would no longer clot with rennet. I shall endeavor to indicate a possible practical application of this fact. Milk curdles under two entirely distinct sets of conditions: (1) it curdles on addition of an acid and (2) it curdles



under the influence of rennet (when the reaction of the milk is either neutral or slightly acid). The two varieties of curd which are obtained under these circumstances may be denominated "acid curds" and "rennet curds" respectively. Acid curds must inevitably be formed in the stomach after milk has been drunk if the gastric contents are allowed to become acid. Such curds (we are familiar with them in ordinary life in the form, for instance, of cream cheese or sour milk) are probably not sufficiently firm to set up digestive disturbances. On the other hand, rennet curds (such as we are familiar with in the form of renneted milk and of ordinary cheese) may be extremely firm. It is therefore in all probability these rennet curds which set up the familiar infantile dyspepsia of bottle-fed children. If this is so, the facts elicited by Arthus and Pagès would appear to be of dominating importance in the treatment of these dyspeptic conditions.

In order to appreciate this correctly the following facts must be attended to: (1) rennet coagulation is delayed and curdling becomes less and less firm as an increasing proportion of the lime salts of the milk becomes precipitated as insoluble salts (Arthus and Pagès); (2) addition of soluble lime salts (up to a certain maximum) causes increased rapidity of rennet-coagulation accompanied by increased firmness of clot (Arthus and Pagès); (3) human milk contains 0.03 per cent. of lime (Bunge); (4) cow's milk contains 0.17 per cent. of lime (Bunge). It is evident from these facts that the rennet coagulation in the human stomach could be delayed by precipitating a portion of the lime salts contained in cow's milk. It is further evident that a great proportion

of the lime salts in cow's milk could be dispensed with without injury to the nutrition of the human infant, inasmuch as the infant, who does not need to walk for more than a year after birth, is fed with milk which is provided with a view to the calf walking almost as soon as it is born. Lastly, the question of a suitable precipitant for the lime in the milk comes up for consideration. As I have already shown, the salts employed by Arthus and Pagès were the fluorides and the oxalates—that is, salts which have poisonous properties and which cannot be employed in dietetics. In lieu of these citrate of soda may be employed as an efficient precipitant. I find in the samples of milk with which I have experimented that an addition of 1 in 200 of citrate of soda—one-fiftieth volume of 25 per cent. citrate of soda—suffices to prevent any rennet coagulation, whilst it can hardly be detected by the palate. Cow's milk with a somewhat less addition of citrate of soda would, with regard at any rate to its lime salts, constitute a true "humanized milk." If it should turn out that the acid curds are also contributory to the dyspeptic troubles of infants, super-addition of the customary bicarbonate of soda or lime-water would apparently be indicated.

#### CREOSOTE IN PHTHISIS.

In an interesting clinical report upon this subject (*Therapeutic Gazette*, July 15th). Dr. Whittaker says:

Considered only from a clinical standpoint, creosote holds its place. It is an easy routine practice, and it is really, as shown, perfectly harmless in any dose. In my wards at the hospital all the tuberculous patients are put upon creosote

immediately upon entry. We begin with 5 drops of a mixture of creosote and tincture of nux vomica, or, where strychnine in large dose is contraindicated, tincture of gentian, in a teaspoonful of whiskey and a tablespoonful of water three times a day after meals; increase the dose a drop daily to ten, whereupon additional doses are given at 10 A. M., 4 P. M., and at bedtime as before. The body shows signs of saturation at 60 drops per day. Six cases were treated also hypodermically with the same dose, but without any appreciable advantage over the internal treatment alone. Four bad cases with marked hectic and forty lighter cases without hectic were treated, in addition, to inhalations in the pneumatic cabinet, and this or a similar method has been tried thoroughly in France, but in my cases, aside from the psychical effect, with no additional benefit.

All our cases in early and even in late non-febrile periods are, and have always been, regularly treated with tuberculin, which remains the only radical redress in pure tuberculosis, but which has no, or, by increase of hyperæmia, only a bad, effect upon the streptococcus infection.

#### CONCLUSIONS.

1. Creosote, when pure, is harmless.
2. It has no direct action upon the tubercle bacillus.
3. Tuberculosis pulmonum is chiefly a secondary infection by a streptococcus.
4. Creosote has no direct action upon this streptococcus; hence none whatever upon hectic fever.
5. It destroys lower organisms, especially those which produce fermentation, without affecting the process of digestion.

Hence, 6, the virtue of creosote, which

is undeniable in most cases, is chiefly, but not wholly, upon nutrition.

#### EXCISION OF THE MEMBRANA TYMPANI AND OSSICLES.

For some time the medical public has been awaiting with impatience the results of the surgical operations devised for the relief of certain ear troubles by the excision of the bones of the ear.

In an elaborate article upon the subject (*Therap. Gaz.*, July 15th), Dr. MacCuen Smith, Aurist to the Jefferson Medical College of Philadelphia, tabulates the results of 154 operations. His conclusions are:

1. Never promise positive results from an operation on the ear for the relief of tinnitus, pain, suppuration, and vertigo. This promise will often be exacted, but the present status of such surgical procedures is not sufficiently defined to warrant us in promising the results which we may hope to attain.

2. Probably no operation in the entire range of surgery (*if carefully performed*) is attended with so little disturbance, either local or constitutional, as excision of the membrana tympani, malleus, and incus, when not complicated with necrosis of the tympanum; in fact, there are very few diseased conditions where surgical operations are so prone to be productive of good results as is excision of the membrana tympani and ossicles in certain ear-diseases.

3. Tinnitus, vertigo, impairment of hearing, and pain are almost certain to be relieved by the removal of the drum and ossicles, if not dependent upon some structural changes in the internal ear.

4. The longer the middle-ear disease has existed (as characterized by tinnitus,



progressive loss of hearing, pain usually not well defined, and possibly vertigo) the greater is the danger of some serious structural lesion of the internal ear, and therefore the less hope of materially improving the hearing-power; and yet, even in extreme cases, the tinnitus, vertigo and pain are more or less benefited, sometimes markedly so.

5. If, after due and proper efforts to relieve progressive aural diseases, you do not produce a speedy and marked improvement, no time should be lost in performing the radical operation; for by delay an internal ear complication may have become established, and this always makes probable benefit more doubtful.

6. It is not well to express too much hope that the operation will materially improve *hearing* in long-standing, non-suppurative cases; and yet, when the chances are so much in favor of its producing entire freedom from tinnitus and vertigo, and especially since there are such great probabilities of a rapidly-progressing disease becoming arrested from the date of operation, it would indeed seem unfortunate if such patients were not offered the benefit of this doubt, if such it can be termed.

7. In all cases where the membrana tympani is thickened, markedly retracted, and made firmly adherent by old inflammatory products to the tympanic walls, and where in this same connection you find the ossicles completely ankylosed, the function of these parts under such circumstances is of course entirely suspended; therefore, in consequence of this condition, this part of the conducting apparatus can be regarded only as a foreign body, and, as such, the only rational hope for relief is through re-

moval, which will in the majority of cases relieve tinnitus and vertigo, while at the same time improvement in hearing can reasonably be expected on account of the opening thus formed admitting the sound-wave which impinges directly on the stapes and fenestra rotunda.

8. As a preventive of necrosis of the temporal bone, mastoid abscess, aural polypi, and serious brain complications, we should, in suppurative cases which resist ordinary treatment, use surgical means to remove all fragments of the membrana tympani and necrotic ossicles.

#### CHLOROFORM-WATER FOR DIARRHŒA.

Dantec and Bonamy (*Internationale Klinische Rundschau*, 1893) are in the habit of using chloroform-water for these cases in a hot climate.

R.—Aquæ chloroformii, sat.,

Aquæ dest., of each, 100 grammes.

To be taken at intervals during the day.

When the diarrhœa is associated with dysentery, chloroform-water is also used, but at the same time the colon is irrigated with antiseptic solution.—*Therap. Gaz.*

#### SOME USES OF POTASSIUM IODIDE.

In irregular malarial diseases, when there is congestion of the liver and spleen, tenderness and enlargement from structural change from interstitial deposits, etc., when cinchona and its derivatives, with iron, strychnine and arsenic, have failed in effecting a cure, iodide of potassium, etc., frequently proves successful.

In hypertrophy with tenderness of the prostate gland, I know from a personal experience that we possess no more useful drug or better remedy than iodide of potassium.



Bartholow and others teach that to remove the deposit resulting from catarrhal and fibrinous pneumonia no remedy is more efficient than is iodide of potassium and ammonium; so also in pleurisy and all the results of such inflammations.

And Ringer declares the fact that in all cases of chronic bronchitis and analogous affections of bronchial and pleural mucous and serous membranes, when there is exudation and effusion as the results of inflammation, even when there is thickening and structural change in the tissues or organs, iodide of potassium is indicated.

Ten grains of iodide of potassium, taken at bedtime, often cuts short an acute cold in the head, especially at its onset.

Ten-grain doses, several times a day, are said to cure that troublesome and obstinate affection, violent paroxysmal sneezing.

With milk this drug is very useful in lead-poisoning.

Iodide of potassium occasionally acts as a powerful diuretic in Bright's disease. Says Ringer: "I have seen it remove all the dropsy in thoroughly waterlogged patients—every part of the body being oedematous, the legs swollen till they could not be bent, the skin shiny from distension, and the abdomen distended with fluid."

Huchard claims to have perfectly cured twenty cases of that excruciatingly painful disease, angina pectoris, by the use of large doses of the iodides.—Dr. Hurd, *American Lancet*.

#### FOR SQUINT.

Mr. Wherry, of Cambridge, recommends an operation for strabismus with a horse-hair loop in cases of internal

squint, when one eye requires a considerable correction, it having the great advantage of avoiding an open wound and stitches in the conjunctiva, although it allows free division of fascia above and below the tendon. In performing the operation, Mr. Wherry uses a strabismus hook having a round hole very near the point, threaded with a long horse-hair. He makes a small opening with scissors and flexion forceps on to the sclerotic below the internal rectus, and then passes the threaded hook behind the tendon. Another small opening is made above the tendon, so that the horse-hair can be pulled through, he then withdraws the hook, leaving the hair behind the tendon, with a free end through the upper and the lower wound. The next step is to pass the unarmed hook in front of the tendon from below upwards through the same openings, thread it with the horse-hair which was left in the upper opening, and withdraw it, including in this way in a loop of horse-hair the tendon and the lower cut. This loop is gently drawn downwards, the scissors being used to cut upwards through the fascia and capsule of Tenon, readily dividing all the included tissues until the loop can be pulled completely through. The eye ball is then rotated outwards, the seat of operation being rubbed smooth. Mr. Wherry finds the above operation very useful as an intermediate method between Graefe's for extreme and Critchett's for ordinary cases.—Correspondence of *American Lancet*.

#### Medical Items.

Dr. J. B. Hamilton has been appointed editor of the *Journal of the American Medical Association*.

The sleeplessness of chorea is one of its most dangerous elements.—*Chicago Medical Times*.

A New York shoemaker has this hospital sign in the window: "Any respectable man, woman or child can have a fit in this store."—*Texas Courier-Record*.

It is said that children well supplied with butter feel the cold less than others and resist influenza better. They do not "catch cold" so easily.

Copper sulphate, one-sixth grain several times daily, in pills, has proved very serviceable to Dr. Isola in the treatment of recurrent *furunculosis*.—*Ex*.

Balfour reports that he has almost never failed to obtain prompt relief in cases of pruritis of the anus and vulva from an ointment containing 80 grains of calomel to the ounce of vaseline or other unguent.

The idea has been suggested that in certain well-known conditions of hysteria a judiciously administered pinch of snuff might have a beneficial effect. Familiar to every one is the perverseness with which such hysterical attacks resist ordinary remedies, and it seems not improbable that some of them might be curtailed by a period of vigorous sneezing.—*Ex*.

An Epileptic Canary.—M. Féré tells us (*Société de Biologie*, June 8th) that epilepsy is not unfrequently met with among birds. Hitherto, however, only two such examples have been recorded in detail. M. Féré has recently had under observation a canary thus affected. The attack commenced suddenly with a

kind of aura, the bird extending its wings. This movement was followed immediately by a turning of the head to one side and then the animal fell. Generalized tonic spasms were then succeeded by clonic spasms, these stages being followed by a period of stupidity, often accompanied by impulsive acts.—*Medical Record*.

To remove the odor of iodoform from the hand.—Dr. W. Washburn, of New York, writes to the *Medical Summary*: Ether and chloroform are both solvents of iodoform, and if the hands are washed with just a trifle, after washing with soap and water, the odor will be missing. The hands have a peculiarly clean feeling after using chloroform, dry instantly, and require no further washing, being in a thoroughly aseptic condition. As nearly every physician carries chloroform or ether in his satchel, and as turpentine would be an additional burden, there is this also in favor of these drugs; they are always at hand.—*Ex*.

Professor Henoch, Director of the Clinic of Children's Diseases in the Charité Hospital, Berlin, has intimated his intention of resigning his chair at the end of the current semester. Prof. Henoch, whose name is known throughout the medical world as the author of a standard treatise on the diseases of children, is seventy-three years of age and has held his present appointment for forty-three years. The names of Prof. Kohts, of Strassburg; Soltmann, of Breslau; and Heubner, of Leipzig, are mentioned in connection with the chair which will be left vacant by Professor Henoch's retirement.—*Ex*.

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## Original Articles.

### ANTERIOR DISLOCATION OF THE LENS IN A CHILD WITH EC- TOPIC PUPILS, AND HOW IT WAS REDUCED.

BY FRANCIS M. CHISOLM, M. D.,

Surgeon to the Presbyterian Eye, Ear and Throat  
Hospital of Baltimore.

In considering dislocations of the crystalline lens, it would be well to glance over the anatomy of this region so that we can the better appreciate how these displacements are produced, and the difficulties in the way of effecting their reduction. The crystalline lens, contained in its capsule, is held in position directly behind the pupil by a more or less complex structure called its "suspensory ligament." This membrane forms a collarette around the lens peri-

phery, and extends outward and backward nearly to the equator of the eye, where its fibres are lost in other tissues. To begin with its origin, which is from the membrana limitans of the retina, at about the ora serrata, it passes forward between the pars ciliaris retinae and the vitreous body, and receives in its course fibres from the anterior hyaloid envelope of the latter. This part of the ligament is free from connection with contiguous tissues, except where fibres from the vitreous envelopes join it. Continuing on, the membrane passes over the ciliary bodies, to the lower portion of which it is loosely attached, moulding itself into folds which fit into the spaces between these bodies. It now breaks up into bands of fibres, some of which become fused with the anterior capsule; less numerous ones go to the posterior cap-



sule; and a few to the marginal covering of the lens. The insertion of these fibres is by fimbriated extremities. The structure of the suspensory ligament is a variety of connective tissue, transparent and very elastic. Stretching as it does from the equatorial walls of the eye, it forms a brace to equalize the strain produced by the action of the intra ocular muscles. Its action, besides holding the lens in an exact central position in relation to the pupillary area, is combined with that of the ciliary muscle in accommodation. In fact, it controls the elasticity of the lens for near objects, and suppresses it for distant vision. It is nourished by contact with sustaining albuminoid fluids, as is the lens, cornea and vitreous body; an imbibition without any direct vascular supply, since no blood vessels have been found in it.

Partial displacements of the lens can only occur through yielding of the suspensory ligament, either because of atrophy of its tissue with stretching from the subsequent weakening, or of traumatism, when the displacement may be complete by extensive laceration of the ligament. In its very formation the suspensory ligament may be defective or even deficient. Atrophic changes which come on, concomitant to changes in the lens itself, with degeneration of the corpus vitrium and its coverings, explain how the membrane will allow the lens to swerve from its normal position. Slight displacements of the lens are often difficult of recognition, and cause no serious disturbance except by the production of irregularities in refraction. The patient has his visual axis diverted from the centre of his lens towards its margin, which is an irregular

refracting medium, not meant to be used, and therefore shut out normally by the iris. The greater curvatures of the marginal parts of the lens thus brought opposite the pupil makes the eyes myopic, with a varying degree of astigmatism. In luxations of greater extent, the lens is pulled so far across the pupil by the elasticity of the unbroken parts of the suspensory ligament, that its edge literally bisects the pupillary area. This makes the patient myopic when looking through the excessive faulty refracting portion, while he is markedly hyperopic on using that part of his pupil area from which the lens has been drawn away. Complete luxations necessitate the destruction or rupture of a large part of the circumference of the ligament. They occur as I have said through atrophic changes, which go on at the same time in the vitreous as well. The thinning continues to a point when any effort of the internal or external ocular muscles is sufficient to occasion a rupture, and the lens falls by its own weight to the bottom of the vitreous chamber, where, with every movement of the eyeball, it can be seen bobbing up and down. In dislocations the lens may remain transparent by continuing to obtain nourishment from the surrounding fluids, or it may have become cataractous, showing intra-ocular degenerations before the rupture of the atrophic suspensory ligament has taken place. Sometimes this occurs in cataract patients who, after years of blindness, are suddenly and without pain miraculously restored to sight. Unfortunately in these exceptional and much talked of instances, the dislocation is often the forerunner of graver intra-ocu-

lar degenerations which gradually result in destroying vision completely and irrevocably.

Anterior dislocations, under which head the case I have presently to relate belongs, are more serious in their immediate results. After a large rupture when the lens is held only by a small hinge of ligament, it swings freely to and fro with each movement of the eyeball. Should the pupil expand much, a slight muscular effort, or a dependent position of the head, may allow it to escape into the anterior chamber, where its irritating presence causes the pupil to contract, and gives rise to a condition which might be called "hernia of the lens." In this unnatural position, making pressure on the sensitive iris and cornea, it sets up iritis with the usual symptoms of pain, and pericorneal redness, which if not relieved calls for surgical interference. The irritating influence thus established may proceed to grave inflammatory troubles unless removed. The presence of a clear lens in the anterior chamber can escape detection and remain under treatment for days as a case of iritis, as it was in the patient now reported.

CASE.—A child three years old was brought by its parents for treatment of an inflamed left eye. They stated that the eye had been painfully injected and had annoyed for two weeks prior to their coming. It had been treated by the family physician during that time as iritis, and had resisted the usual remedies applied by him. On examining the eyes of the child, a peculiarity was at once noticed, namely, that both pupils were irregularly placed, not being in the centre of the iris, but wholly in the upper and outer quadrant. In the right eye

the iris was otherwise complete and normal in its appearance. In the left eye there was some congestion and sensitiveness, with a marked pericorneal injection. On closer inspection the anterior chamber seemed to have an irregular and greater depth than usual. The iris appeared to be cup shaped and pressed backward, except at one part where the pupil margin was drawn forward as by some attachment from behind. The reason of this was due to an anterior displacement of the lens, which was occupying almost the whole space of the chamber and was causing irritation by its pressure on neighboring parts; the part of the suspensory ligament by which it was still attached to its ciliary connection was lifting the pupil margin at one place, as was first noted. Attempted reduction by position and pressure over the cornea, after a free use of atropia, proved ineffective, since the pupil had contracted too much to allow of the lens getting behind it, and the remaining space in the anterior chamber was filled up with liquid which could not be displaced; the lens acting as a stopper to the pupillary opening. Recourse was then had to operative means. Under chloroform anæsthesia a puncture was made at the nimbus of the cornea, permitting all the aqueous to drain off. After the partial emptying of the eyeball, pressure from without was brought more directly on the lens. Then by repeated efforts at manipulation, through the cornea, the free edge of the lens was pushed under the margin of the pupil. This was the beginning of the reduction and by following it up the whole lens was pushed back. It suddenly disappeared behind the iris, which septum immediately resumed its normal appear-

ance. Eserine was used to contract the pupil and prevent a return of the trouble.

The emptying of the anterior chamber was the essential part of the procedure, as otherwise the lens would have resisted any attempt at moving it.

114 W. Franklin Street.

### THE ADVANTAGES OF ANTISEPTIC IRRIGATION OF THE PARTURIENT CANAL BEFORE AND AFTER LABOR.\*

BY T. RIDGWAY BARKER, M. D.

"To avoid danger is a thousand times wiser than to prepare to meet it."

Prompted and emboldened by this thought, I present for consideration and discussion the advantages to be gained by the employment of ante-partum and post-partum vaginal irrigation.

Having accepted as proven the role which micro-organisms and their products, ptomaines, play in the development of disease, it has been my practice for the past two years to employ, in cases of confinement, irrigation of the parturient canal.

The results from this routine method have been so uniformly satisfactory, aside from any theoretical considerations, that I would fain persuade every practitioner of obstetrics to give the plan an impartial trial.

While it has, I am well aware, no definite claims to novelty, yet the rules governing aseptic midwifery are so generally disregarded in private practice that further study cannot be otherwise than beneficial.

It is certainly a fact that strong anti-

septic solutions containing mercury or carbolic acid are likely to, and will, if long continued, poison the patient. Garrigues, in his paper on "Corrosive Sublimate and Creolin," published in *The American Journal of the Medical Sciences*, 1889, reports twenty cases of death from this drug in obstetrical practice. But any valuable remedy will fail to give good results if not properly administered. Therefore, its abuse cannot be said in any way to militate against its use.

The method which has given me the best results consists in having the external parts about the genital region carefully and thoroughly scrubbed with soap and hot water with the onset of true pains. This is followed by a second cleansing with 1 to 1000 bichloride of mercury solution, the final washing being with boiled water. This completes the toilet of the entrance to the vestibule of the birth canal. As to the treatment of the canal itself, a fountain syringe is filled with one quart of hot, boiled water containing bichloride of mercury 1 to 5000. The ordinary nozzle made for vaginal use, after being rendered aseptic, is introduced into the vagina and carried up to the anterior vault of the canal, the stream of water having been running freely before introduction, to expel all air from the tube. When about half the solution has been used in bathing this portion of the vagina the nozzle is slightly withdrawn and made to enter the posterior pouch. In this way the whole mucous surface is irrigated, and at the same time some of the overflow bathes the cervix.

It is very desirable to finish this step in the procedure before the rupture of

\*Read before the Philadelphia County Medical Society.



the membranes, as their presence tends to prevent the escape of the antiseptic fluid into the uterine cavity and between the uterine wall and decidua. It will be noticed that so far our ante-partum efforts at cleanliness have been principally confined to the vagina, and this is the point to which our attention should be especially directed, for the source of infection is far more likely to lurk here than in the pregnant uterus.

The vaginal douches are to be administered with the female in the semi-recumbent posture, in order that free drainage may be secured and no fluid permitted to collect behind the posterior margin of the vulva. The antiseptic irrigation is to be followed by a free bathing of the parts with boiled water, so that absorption of the mercury may be rendered impossible. By these means we run no risk of mineral poisoning, while we do secure a perfectly aseptic condition of the birth canal.

When can we, without such precautions, say, with any degree of certainty, this woman's birth-canal contains no gonococci or other noxious germs? Her family life may have been the purest in every particular, yet gonococci may be present. The occupation of the husband, as Lapthorn Smith, of Montreal, has pointed out, through a lack of personal cleanliness, may infect his wife. Such occupations as scavenging, rag-picking, and the like, render a man especially liable to infection when the simplest rules of hygiene are neglected. The same author pertinently remarks, "Before labor begins we should disinfect the vagina of all women whose husbands have had gonorrhœa, taking it for granted that all have had it unless we have proof to the contrary."

Some writers, in spite of such facts, declare antiseptic irrigation unnecessary, because, they argue, that Doderlein's experiments, as to the nature of the micro-organisms found in the healthy vaginal canal, prove conclusively that they are non-pathogenic; but I would make answer, that what is harmless in a healthy vagina with a perfect mucous membrane is not necessarily so when its walls have been overstretched and are the seat of lacerations. The science of bacteriology has not yet declared the law that non-pathogenic micro-organisms always remain so under all conditions and circumstances.

Among those who are opposed to such prophylactic measures as I have suggested, may be mentioned Rosenberg, of the New York Polyclinic, who states in a paper published in the *Medical Record*, February 4, 1893—"So far I have not said anything about the prophylactic vaginal douches, and I only wish to speak about them to condemn their routine administration. I do not believe that the vagina can be made sterile, no matter how much douching is done; but I do believe that infectious material is very frequently carried into the genital tract by dirty instruments or fingers."

Now it goes without saying, that if you are going to employ dirty instruments and fingers in your pseudo attempts at aseptic midwifery, you had better avoid examining the patient at all. In fact, it would be wiser to secure some one else to take charge of the case. Therefore, such an argument is fallacious.

But what is still more surprising is that the same writer in his article should cite, in support of this view, several cases of puerperal infection in which the

woman died. They were supposed to have aseptic parturient canals, when in reality septic matter had been introduced by unclean midwives in their efforts to ascertain the female's condition previous to the arrival of the medical attendant.

Here we have a striking example of our inability to distinguish between an aseptic and a septic birth-canal. The life of the woman is thus risked unwarrantably when we have nothing but pure assumption on which to base our opinion.

Some extremists have gone so far as to recommend the employment of vaginal antiseptic injections as early as one week, or more, before the onset of labor, and they advise continuing them until the first stage is well advanced.

This is, perhaps, carrying the principle of antiseptics too far, but better than not far enough. The importance of having an absolutely clean nozzle to the syringe cannot be too forcibly impressed. Dirty tools can never be expected to do clean work.

Earle, in a paper published in the *Chicago Medical Journal and Examiner*, tersely remarks, "You cannot carry out intra-uterine injections with a half-ounce syringe and a goose-quill." Were the benefits arising from vaginal irrigation previous to delivery wholly included under the term asepsis, we might rest well-satisfied, but that is not all, for the hot fluid fills a useful purpose in softening the cervix, thereby lessening the pain incident to its dilatation.

Some may urge against the practice that it washes away the natural mucous secretion which is intended to lubricate the parts and facilitate the passage of the infant, but this is a theoretical objection which has no existence in fact.

Quite the reverse one finds to be the case, which is confirmed by Garrigues, of the New York Maternity, who states, in a paper read before the Section on Obstetrics and Gynecology, in 1892: "Personally, I am opposed to rubbing and scrubbing the vagina, as some think necessary, but as to a vaginal injection before delivery, I believe yet that it is useful. It will remove both dirt and microbes, and if, at the same time, it removes a layer of mucous that lubricates the vagina, and, therefore, protects the perineum, it is easy to see that new mucous is poured out in abundance to replace the first."

With an aseptic parturient canal our fears of infection of the eyes of the infant, as it is driven along, are practically *nil*, for there is nothing to give rise to ophthalmia, that terrible disease so fatal to the sight. As my paper does not concern itself with other necessary precautions, such as those relating to the clothing and the person of physician, nurse and patient, no mention will here be made of them.

Having outlined the ante-partum procedure which would seem to recommend itself to the careful accoucheur, we have still for consideration some post-partum measures.

Whether the case has been one of natural or instrumental labor makes no difference; all must be treated alike, save the latter class will require extra care and attention, since the doors for the entrance of septic matter are more numerous and wider open.

No matter how skilfully one may have delivered the placenta and secundines, we never can know positively whether everything has been expelled. Let the

examination of the placenta be ever so minute, a fragment may be left behind, or a shred of membrane that the eye of the attendant has failed to note the absence of.

Appreciating this fact, it is but fair to assume that there is in every uterus after delivery, a cavity which contains material which, if it becomes infected, will place the patient in great danger. Micro-organisms feed on dead tissue, and by their multiplication pour out ptomaines which, when brought into contact with living cells, cause their death.

Thus is formed the virulent poison which the vessels are ready to suck up and carry through the system. Let the source of the pathogenic organism be what it may, we do know that when it takes up its residence in the utero-vaginal canal it is a terrible enemy to do battle with. Therefore, it would seem but reasonable to institute prophylactic measures to prevent the entrance and development of these breeders of disease, which can best be accomplished by the employment of antiseptic irrigation.

Mercury in the form of corrosive sublimate is scarcely suitable for post-partum vaginal irrigation, since it is so readily absorbed by abraded surfaces. Hence, carbolic acid, creolin, boric acid, or peroxide of hydrogen are to be preferred. The advisability of resorting to irrigation immediately after the labor is questionable, since the likelihood of inducing hæmorrhage, introducing air or irritating fluid into the yet unsealed uterine sinuses is possible.

After the lapse of twenty-four hours, however, I would recommend a vaginal douche of carbolic acid, one drachm to the pint, or creolin, one per cent., fol-

lowed by an equal quantity of boiled water.

It would appear from a study of the clinical symptoms of puerperal infection, that the first manifestations occur on the third or fourth day; in other words, the lochial discharge in the first twelve hours is so free that no contamination by micro organisms is possible, but on the second day, the discharge not being so abundant, the germs gain a footing, and after a lapse of twenty-four hours pour sufficient poison into the bloodstream to jeopardize the life of the female.

Earle quotes Bakelmann as deeming intra-uterine injections indicated when, forty-eight hours after birth, the temperature rises to  $101.5^{\circ}$  F. to  $102.2^{\circ}$  F., with frequent pulse, without a recognizable cause for it; also, when fragments of placenta and membranes remain in the uterus as a cause for disturbance, and when symptoms of infection of the endometrium are present.

Of course he does! Who would not under such circumstances? But where is the wisdom of waiting until these disintegrating masses become infected before bringing about their expulsion? Why, indeed, delay in removing the oil-can, so to speak, from the neighborhood of the fire when experience unmistakable teaches us that it will explode if only left there long enough? Let us, at least, be reasonable and hasten with all judiciousness to place beyond reach the dangerous element.

If our knowledge of septic processes is worth anything it surely ought to convince us that disintegrating organic matter has no place beside the living, and the wider the range of separation



the safer for the individual. When we resort to vaginal irrigation at the expiration of twenty-four hours, we find the canal in a condition suitable for such a procedure. If the amount of carbolic acid does not exceed one drachm to the pint of warm water, and free drainage is secured, surely no poisoning is possible. Too much stress cannot be laid on the importance of having the female occupy a semi-recumbent position so that the escaping fluid may tend to gravitate toward the patulous vulvar orifice. The pressure by which the solution is forced into the passage should be as low as possible, the object being to irrigate rather than inject.

As is well known, when the woman lies on her back the discharges accumulate at the posterior and inferior portion of the vagina and form a pond well-suited to become the feeding ground for pathogenic organisms. By destroying this nest, which antiseptic irrigation accomplishes, we stop the production of ptomaines and relieve the system of further danger from infection. Appreciating, therefore, the great advantages and the increased safety to the parturient, can we do better than adopt for our motto in obstetrics, and carry out in practice—"CLEANLINESS FIRST, LAST, AND ALL THE TIME."

#### SWALLOWING A WATCH.

The freaks of lunatics are sometimes extraordinary, and one of the most remarkable which has been placed on record recently is that which Dr. Vallow has published in the current issue of a French contemporary. A man, aged thirty-seven, was confined in an asylum suffering from hallucinations, and one day, his wife having come to visit him,

he was permitted to see her. When the allotted time of the interview, according to the rules of the institution, had come to an end, his wife intimated that she would have to take her departure, whereupon the patient, judging that she wanted to leave him before the time had expired, flew into a violent passion and accused her of deceiving him. To prove however, the truth of her statements, she drew out her watch and showed him the time, but as soon as the patient saw the watch, he suddenly seized it in his hand, tore the chain from it, and putting it in his mouth, swallowed it. The medical officer of the asylum was summoned at once, but the patient in no way appeared to have suffered from his curious freak. On examination of the stomach nothing could be felt, and it was at first believed that, after all, the watch might not have been swallowed. However, all due precautions were taken and on the sixteenth day the watch arrived *per naturalem viam*. It was a silver watch measuring about two inches and a half in diameter, exclusive of the ring, and about half an inch in thickness. —*Medical Press.*—*Ex.*

The Postmaster-General has formally announced that since disease germs, no matter how securely sealed, are of a poisonous character and are extremely dangerous to the public health, they are, therefore, classed with unmailable articles.

It is said that lactic acid, in about the proportion of 3 drops for 15 grs. of quinine sulphate, makes an excellent excipient for quinine pills. A somewhat larger quantity will be required, if other solid substances are incorporated. —*Jour. Arkansas Med. Soc.*

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A. K. BOND, M. D., Editor.

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BALTIMORE, AUGUST 19, 1893.

**Editorial.**

**POINTS ON OPIUM.**

In the *Boston Medical and Surgical Journal*, June 29, Professor H. C. Wood presents some very interesting observations concerning the uses of opium.

The difference observed in its action upon animals and upon man is first discussed; the author holding that the existence of a uniform law of action upon all members of the animal kingdom is not contra-indicated by the peculiar differences observed after the administration of opium.

That in man, opium acts chiefly upon the brain, causing stupor, while in the lower animals it acts chiefly upon the spinal cord causing convulsions, is to be explained by the increasing predominance of spinal activity over cerebral activity as the scale of intelligence is descended.

Another point of interest brought out by Dr. Wood is that the stupefying sequels of opium poisoning are largely attributable to carbonic acid gas poisoning.

The opium lessens the reflex activity of the respiratory centres, lowering the respiration-rate and making the inspirations shallower; and the impure blood, charged with carbon dioxide, does the rest. The aim of the physician in such cases is to correct this state of carbon dioxide stupor by direct production of respiration; and if this succeeds, the patient's nerve centres will be freed in time by excretion from the benumbing influence of the opium. (It really seems as if artificial production of respiration if continued long enough in the proper way would save almost all ordinary cases of opium poisoning.)

The treatment of opium poisoning is:

*First*, by emptying of the stomach; and here apomorphia hypodermically is indicated in spite of its derivation from morphia.

*Second*, by respiratory stimulants, of which the best are cocaine, strychnine, and atropine. These all increase the volume of inspired air. Dr. Wood has observed that when the full effect of one of these drugs has been reached the administration of another of the three will deepen the inspirations still farther. Thus, when strychnine had done its best in a case of pneumonia-asphyxia, cocaine aided its action and seemed to be the agent which saved the patient.

*Third*, by artificial respiration. Here forced respiration, after tracheotomy, with a bellows; forced respiration in the same way, without tracheotomy, but with a mouth and nose piece; or with intubation; stimulation of the skin with the wire-brush electrode; common artificial respiration; are all of value.

These agencies should never be discontinued as long as the heart is beating.



Heat is an aid to respiratory activity, and so hot applications are indicated.

Oxygen is good if continuously inspired for a long time.

It is often impossible to tell whether paralysis of the respiratory centre, caused by excess of carbon dioxide in the blood is a consequence of opium poisoning, of uræmic poisoning, of lung paralysis, or of paralysis of the lower brain. The medical witness should testify that the symptoms are "in accord with opium poisoning, but might be due to one of the other causes."

In treating diseases of children, mechanical mixtures of opium and other drugs, as in Dover's powder, should be looked upon with suspicion, as the opium may not be evenly distributed by a careless druggist.

The child of an opium-eating parturient is always at birth an opium-eater, and may die soon after birth if opium is not given, for a time, in lessening doses, to replace that received through the mother's blood.

### THE LONDON POST-GRADUATE COURSE.

Some time ago we called attention to the advantages offered by this post-graduate course for clinical study in the great hospitals of London during the winter months. Very recently we were informed by an American physician who had been in London that the course was a great success. We therefore receive with pleasure its prospectus for the winter of 1893-94 (October 9 to December 2).

The course, of which Jonathan Hutchinson is president, was founded in Jan-

uary, 1890; and is, as we understand, open to all physicians of good standing in England and elsewhere.

During the winter term (October, November and December, 1893), instruction will be given by members of the medical staffs of the following hospitals:

The Hospital for Consumption and Diseases of the Chest, Brompton. The Hospital for Sick Children, Great Ormond Street, Bloomsbury. The National Hospital for the Paralyzed and the Epileptic (Albany Memorial), Queen Square, Bloomsbury. The Royal London Ophthalmic Hospital, Moorfield. The Hospital for Diseases of the Skin, Blackfriars. Bethlehem Royal Hospital for Lunatics. The London Throat Hospital, Great Portland Street.

The teaching will be, as far as possible, of a practical character, including demonstrations of selected cases, and lectures on the diagnosis and treatment of the diseases for the study of which the above-mentioned hospitals afford facilities. There will be instruction in the use of the microscope, ophthalmoscope, laryngoscope, and aural and nasal specula. The twelfth course will consist of eighty-eight lectures or demonstrations.

There will also be included in this course a series of clinical lectures in the Cleveland Street Sick Asylum, in which the following eminent instructors will give bedside lectures: October 12, Jonathan Hutchinson; October 19, Dr. Bristowe; October 26, Thomas Bryant; November 2, John Croft; November 9, John Hopkins; November 16, Reginald Harrison; November 20, John Hopkins; November 30, A. Pearce Gould.

The fee for attendance at any single



course will be £1 1s., or £2 2s., according to the number of lectures and demonstrations.

The fee for the whole course will be £11 11s.

The practice of the respective hospitals is open to gentlemen attending the post-graduate course on the following terms: Hospital for Consumption, Brompton—£1 1s. for one month; £5 5s. six months; £10 10s. perpetual. Hospital for Sick Children, Great Ormond Street—£1 1s. one month; £3 3s., for three months; £5 5s. for twelve months. Royal London Ophthalmic Hospital, Moorfields—£1 1s. for one month; £3 3s. for six months; £5 5s. perpetual. London Throat Hospital, Great Portland Street—£1 1s. for one month; £2 2s. for three months; £5 5s. perpetual.

The conditions of attendance at other hospitals may be learned on application.

Fees may be paid by crossed cheque or postal orders to the Secretary, J. Fletcher Little, M. B., at 32 Harley Street, Cavendish Square, London, W., to whom all applications for cards of admission and enquiries for further information are to be addressed.

The spring term is from January 16 to March 11, the summer term from May 1 to June 26.

### Correspondence

#### THE TREATMENT OF THE MORPHINE DISEASE.

*Editor Maryland Medical Journal:*

SIR:—To any one who may desire it, I shall take pleasure in sending a paper giving, in full detail, a method of treat-

ing morphinism that is simple, satisfactory and successful; and far in advance of any mode yet presented to accomplish two cardinal objects—minimum duration of treatment and maximum freedom from pain.

J. B. MATTISON,

Medical Director, Home for

Habitues, Brooklyn.

188 Prospect Place, Brooklyn, N. Y.

### Reviews, Books and Pamphlets.

We have received the first number of a new monthly, "*The Journal of Surgery Gynecology and Obstetrics*," edited by C. Evans Johnson, M. D., with the collaboration of twenty-six specialists and surgeons. It is published in Atlanta, Georgia; and is, both in form and in matter, a very promising addition to specialistic literature, as well as a credit to our enterprising sister city.

This first number contains original articles by Drs. W. W. Keen, of Philadelphia, Wm. Perrin Nicholson, of Atlanta, Howard A. Kelly, of Baltimore, George Erety Shoemaker, of Philadelphia, and Frank W. Talley, of Philadelphia; with transactions of the New York Surgical Society and the Obstetrical Society of Philadelphia.

### Pan-American Congress.

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#### SECTION ON MATERIA MEDICA AND PHARMACOLOGY.

A Section on Materia Medica and

Pharmacology has been organized under the Executive Presidency of Professor Joseph P. Remington, of Longport, N. J., with Professor F. G. Ryan, 3739 Brown St., Philadelphia, as English-speaking Secretary. This Section promises to be one of the most important of the entire Congress. Delegates have been invited from all the pharmaceutical societies and colleges in all the Americas. Those contemplating attendance are invited to prepare papers on pharmaceutical topics. Titles should be sent at once to Professor Ryan, Secretary.

#### PROGRAM OF SECTION ON PATHOLOGY.

Special attention of the profession is called to the Practical Demonstrations in Pathology, Photo-Microscopy and Bacteriology.

One session will be devoted to a formal discussion on the subject of Cancer, to be opened by Dr. Wernicke, of Buenos Ayres, and continued by Professor Allen J. Smith, of Galveston, as co-referee. Papers on this subject have been promised by Dr. Joshua M. Van Cott, Honorary President of the Section, and Dr. Joseph McFarland, of the Advisory Council.

Another session will be devoted to Yellow Fever; the discussion will be opened by Drs. Acosta and Grande, of Havana, Cuba, and, as co-referee, Dr. A. J. Amadis, of Puerto Rico, Honorary President.

One day, two sessions, will be devoted to Practical Demonstrations, as follows: Dr. James E. Reeves, of Chattanooga, of the Advisory Council: Practical Demonstration of the Methods in Pathological Histology. Dr. Wm. M. Gray, of the Army Medical Museum: Practical Demonstration of the Methods in Pho-

tography applied to Pathology. Dr. J. J. Kinyoun, P. A. Surg. U. S. Marine Hospital Service: Practical Demonstration of Methods in Bacteriology.

Papers have been promised as follows: Notes on Three Years' Work in the Pathological Laboratory of the Charity Hospital of New Orleans, by Dr. Henry Dickson Bruns, of New Orleans. Medical Geography of Puerto Rico, by Dr. A. J. Amades, of Puerto Rico. Theories of Inflammation, by Dr. Jose Torres Matos, of Havana. On Inflammation, by Dr. E. O. Shakespeare, Philadelphia. On Cholera, Dr. Herman M. Briggs, of New York. L'état de Hyperexcitabilité du Nerf Phrenique, dans le Beribiri, by Dr. J. B. de Lacerda, of Rio de Janeiro. Paludismo, by Dr. A. J. Amades, of Puerto Rico. Bacteriological Observations on the Waters of the Harbor of Havana, by Drs. Acosta and Grande. Observations on Malaria, by Drs. Coronado and Madau. Operations of the Anti-rabic Laboratory in Havana, by Dr. Acosta. Abscess of the Liver, by Dr. James E. Reeves, of Chattanooga. On Influenza, by Dr. Ramon Guiteras, of New York. Observations on the Brains of Feeble Minded Children, by Dr. Henry W. Cattell. Pathology of Pelvic Inflammatory Trouble, Dr. Joseph Price, Philadelphia. Papers have been promised, without giving the subject, by Professor Wm. H. Welch, of Baltimore, by Dr. W. J. Councilman, of Boston; and by Dr. G. F. H. Nuttall, of Baltimore, and Drs. Wm. Hughes and W. J. Carter, of Philadelphia.

Tincture of myrrh well diluted is an excellent application for inflammatory pruritus.—*Ex.*

## Medical Progress.

### AFTER REMOVAL OF TUBES AND OVARIES, WHAT?

In a recent discussion in the Obstetrical Society of Philadelphia, Dr. Noble (*Jour. Surgery, Gynæcol. and Obstet.*, July) said:

I would like also to say a word about the statement that very many women who have had the ovaries and tubes removed suffer very much more than they did before the operation. I wish to say that without an exception I have never had a patient tell me that. It must take a very curious type of mind to interpret the complaints some of these women make of the functional disturbances due to the menopause, and which disappear in the course of twelve or eighteen months, into the statement that they suffer much more than they did before the operation. There is no doubt that all of these women are not restored to health, and why is this true? My observation has been that the women who have not been restored to health belong to one or two classes. They are those who have carried pus tubes or suppurating tumors for so long a time that their constitutions are absolutely wrecked, and their recuperative powers so greatly reduced that restoration to health was impossible, or, on the other hand, as a result of delay and repeated attacks of peritonitis, the abdominal and pelvic viscera have become so adherent that in order to remove the focus of the disease it has been necessary to leave the pelvis pretty well stripped of its peritoneum. Adhesions of the abdominal viscera take place in some of these cases and at times cause a great deal of pain, sometimes requiring a



second operation for its relief; but surely these partly good results cannot be charged to the abdominal surgeon, but rather to those who oppose the rational treatment of incurable pelvic conditions, and who exert their influence to prevent suffering women from having the benefit of early operative treatment, before their constitutions have been broken down by long-continued illness, or the abdominal and pelvic viscera have been completely matted together by repeated attacks of peritonitis. The operation of the surgeon cannot influence these physical conditions, nor will it influence the anæmia and the neuralgias from which many of these women suffer as the result of long-continued disease.

#### TREATMENT OF ASTHMA.

In the *Texas Courier-Record* Dr. Buster gives the following treatment:

In the treatment of asthma the cause should be ascertained and removed as far as possible.

In the management our first object is to relieve the patient of the paroxysm, which is effected by the hypodermic of morphine, atropine or hyoscyamine; or by inhalation of ether, chloroform or nitrate of amyl; but these are not to be used beyond stimulation.

By mouth any of the above named medicines or some alcoholic preparation, bromides, chloral or trinitrin may be administered.

With us the most gratifying results have followed the use of ext. of Quebracho with belladonna. We administer one drachm of the former with three to five drops of the latter, then follow with one-fourth the amount every twenty minutes until relief or till the maximum dose of belladonna is given.

We have never had this to fail where the stomach would tolerate the medicine.

When the bronchial secretion is scant lobelia or ipecac often give relief; the latter is generally to be preferred on account of its less depressant action.

The treatment in the interval must be directed to removal of the causes, whether internal, systemic or external.

If the neurasthenia is caused by functional or organic uterine disorders, a special treatment must be given to remove the trouble.

Strychnine in full doses is curative in many cases.

Iron, quinine and arsenic are valuable, as nerve and general tonics; but in order to have their best effects, we give mercury and iodide of potassium to stimulate molecular change.

#### FOR IMPOTENCE.

The following case illustrates a method suggested by Dr. King in the *Boston Med. and Surg. Journal* to remedy a condition which usually plunges those subject to it into the most deplorable state of mental suffering:

Mr. M., aged thirty-five, a laborer of powerful physique, came to me about a year ago with the following history: For several years he had been losing the power of maintaining an erection, during the past year its duration having been so short that sexual intercourse had been rendered impossible. There was a loss of sexual desire and great mental depression. Excessive use or abuse was the cause of this condition.

I gave all possible encouragement to the patient; advised total abstinence from sexual intercourse, cold baths (especially to the spine and external genitals); prescribed bromides, cannabis indica, can-

tharides, damiana, phosphorus and salts containing it; pushed strychnine as far as it could be borne; gave various tonics; used electricity; and, in short, tried everything which offered any hope of success, but all to no effect so far as producing any stronger erection was concerned.

Careful study of the case convinced me that the immediate cause of the trouble was a physical one, due to a leakage, as it were, or to a too rapid escape of blood from the penis when erected. I therefore determined to ligate a couple of the larger subcutaneous veins at the base of the penis and watch the effect.

This was very easily done by the use of cocaine. A vein on each side of the penis was exposed, ligated in two places and severed between the ligatures. A dressing was lightly applied and held in position by a strip of adhesive plaster placed longitudinally. The result was immediate. In less than five minutes after leaving my office he had an erection. That night he was awakened by a powerful erection which made the bandage so painfully tight that he was obliged to jump out of bed upon the cold floor to subdue it. Primary union was prevented by the frequent erections, but the success of the operation was certain.

Two months later he reported himself well, mentally and physically; his sexual appetite had returned, and since the operation, his power of maintaining erections had been as good as ever.

#### CHLOROBROM IN SEA-SICKNESS.

Dr. Ledingham, Surgeon-Superintendent of the Queensland Government Emigration Service, makes the following

communication to the *Lancet* touching the therapeutic virtues of this drug:

After an extended trial of chlorobrom in marine practice where the patients were under observation for some months I have no hesitation in pronouncing it the most satisfactory remedy yet produced for the treatment of sea-sickness. In those cases particularly where the patients, though not suddenly and violently sick, were in a state of chronic misery with headache, nausea, great depression, sleeplessness and no appetite (a condition frequently dangerous in delicate people undergoing a long voyage) I have found chlorobrom properly administered most valuable; as a rule, the nervous symptoms disappear and the patients never fail to gain refreshing sleep and generally make a rapid recovery. Its ease of administration, safety, and complete absence of objectionable after-symptoms are points of great importance. I have also found the solution exceedingly useful in many cases of insomnia and nervous derangements.

#### TREATMENT OF HEADACHES.

Collins (*Med. Record*, April 2nd, 1892) leaving out of consideration migraine and neuralgia, adopts Dana's classification, with a few modifications, based on the etiology of headache, namely, 1. hæmic: (a) anæmia (b) hyperæmia, (c) diathetic states (gout, rheumatism, lithæmic and auto-toxæmic conditions); (d) infections; (e) uræmia, diabetes. 2. Toxic: lead, alcohol, tobacco, drugs. 3. Neuropathic states: epilepsy, neurasthenia, chorea, hysteria, etc. 4. Reflex: ocular, dental, naso-pharyngeal, auditory, dyspeptic, sexual, uterine, etc. He considers that the salicylates and chloride of

ammonium rank first among medicinal agents. Salol or salicylic acid is the best form in which to give this remedy, and it is of most importance in diathetic, toxic, and auto-toxæmic states. It is of advantage to combine this drug with a mineral acid in these conditions, as the latter prevents the formation of uric acid compounds. Chloride of ammonium is particularly useful when headache is associated with loss of appetite, sickness, bad taste in the mouth, flatulence, stuffiness of the bronchial tubes, etc., and should be given in the form of wafers containing 3ss to 5j every two to four hours for three doses. Headaches dependent on diminished blood pressure are frequently relieved by sipping, for example, taking a glass of cold water by mouthfuls. Mastication, sniffing irritant substances, exposure to cold, and excitement serve the same purpose. The action of cardiac neurotics is evanescent, particularly the diffusible stimulants, which have the additional disadvantage of often leading to the formation of a habit. Where congestion is the cause ergot should be given internally, and derivatives applied to the extremities, or the external application of cold, frequently assisted by a dose of bromide, is of service. Galvanism to the cervical sympathetic also frequently gives relief. When it depends on stomachic hyperacidity without constipation, bicarbonate of soda gives relief; but when sluggish digestion with constipation is present, acids and simple bitters should be used. In reflex headaches the cause must of course be removed. Collins considers that the employment of the recently introduced coal tar products such as antipyrin, etc., is to be avoided, as, while

relieving transitory neuralgic headaches, they exert no influence on the cause. The treatment between attacks consists in preventing and overcoming every perverted condition on which the pain may depend, and building up the system. One measure is especially of use, namely, water, both internally and externally, but especially the latter. Those headaches which are dependent on hæmic and vascular changes are most benefited by the application of cold water in the form of shower, plunge, or needle bath, etc.; while those dependent on neuropathic conditions derive most good from the cold pack.—(From an abstract in the *Canada Med. Record*.)

#### THE CLEAN OBSTETRICIAN.

In closing an article on Obstetric Practice, Dr. Amis (*Jour. Arkansas Med. Soc.*, June 16th) expresses these admirable sentiments:

I feel that aseptic midwifery is as much a possibility as aseptic surgery, and I trust that in the near future the whole profession will awake to the full appreciation of the importance of this field of usefulness, and that obstetrics will become as much a science in the village and at the crossroads as in our great maternity hospitals; and that the obstetrician of the future will not only be a man of clean heart and noble purposes, but will be a man with clean hands, clean linen, clean instruments and clean sponges, and who will have clean patients in clean beds and clean surroundings, and in addition to cleanliness, will keep in mind gentleness in his manipulation, and avoid meddlesome and unnecessary examinations, look well to the comfort of the patient, and one who



will not be afraid of fresh air during the puerperal period.

I will add, in conclusion, that it is my opinion that in the obstetrics of the future proper application of the nail brush will save more lives than the forceps, and that hot water and soap will save more lives by preventing than all the drugs of the past have done by curing septicemia. And not only this, but by the profession laying the clean hand of merit upon this field, which by right belongs to it, and by turning on the light of science will bring the people to a more proper appreciation of the difference between science and ignorance, and thereby cut off many a charlatan from gaining his daily bread by imposing on innocent ignorance; and the sign, "Mrs. So-and-So, Midwife," so commonly seen in our larger towns, will be taken in to be seen no more, because the people will have been taught to appreciate the importance as well as the dangers of child-bearing.

#### POST-PARTUM APPENDICITIS.

Dr. H. M. Neale, in the *Medical Record* for July 1, 1893, states that he has discovered several cases of post-partum appendicitis, and he believes many of the cases of so-called post-partum cellulitis, pelvic abscess, ovaritis, and salpingitis, to be in reality appendicitis. This opinion is quite in line with my own observations in cases in which coeliotomy has given opportunity for verifying the diagnosis. Dr. Neale supposes that because labor contractions subject the abdominal contents to a high degree of pressure, cæcal contents are forced into the appendix, causing inflammation. This latter theory is not borne out by post-operative examination of specimens.

Child-bearing women and athletes frequently crush the adenoid layer of the appendix by subjecting the appendix to forcible compression against the pelvic wall. Symptoms of appendicitis may then appear almost immediately or after the lapse of weeks or months, the extent of the disturbance depending principally upon the amount of exudates in the tissues of the appendix, and the resulting opportunity for bacteria to make inroads and excursions. Prompt operation through the inch-and-a-half abdominal incision, by good surgeons, should give, in appendicitis, the death-rate of tooth-extraction, and will confine the patient to bed for a few days only, leaving an unimportant scar.—Dr. Robert T. Morris, 133 W. Thirty-Fourth St., New York, July 1, 1893, in *Medical Record*.

#### THE TREATMENT OF SUPPURATIVE BUBOES.

Otis (*Journal of Cutaneous and Genito-Urinary Diseases*, vol. vi, No. 5) treated sixteen suppurative buboes according to the following method. The skin for some eight or ten inches about the affected area was rendered thoroughly aseptic by scrubbing with green soap, washing with sulphuric ether, and then douching with a solution of mercuric chloride 1 to 1000. A narrow bistoury was then inserted into the abscess cavity, and the contents gently but thoroughly squeezed out. The cavity was irrigated with a solution of mercuric chloride 1 to 2000, and immediately filled to moderate distention with warm iodoform ointment (ten per cent.), care being taken not to use a sufficient degree of heat to liberate free iodine. The syringe used for introducing the oint-

ment was the ordinary cone-pointed, glass, clap syringe. The plunger being removed, the barrel, gently warmed in the flame of an alcohol lamp, was filled with the ointment by means of a spatula, and the plunger replaced. On finishing the injection, at the instant of withdrawing the syringe from the wound, a compress wet with cold bichloride solution was applied, which instantly solidified the ointment at the orifice, preventing the escape of the contents of the abscess cavity. A large compress of dry bichloride gauze was then applied, covered by a protective dressing of cotton, and retained by means of a firm spica. The patient was requested to return at the end of four days. If all was well at this time, the dressing was simply reapplied; but if there were any evidences of inflammatory action, the wound was thoroughly irrigated and cleansed, and the injection repeated.—*Ex.*

#### GLAUCOMA OVERLOOKED.

The following plea for caution is presented in an article by Dr. Bullard in the *Medical and Surgical Reporter*, August 5:

I only wish that I was able to portray to your minds the true realities of which I speak. In an effort to do so, allow me to quote from a lecture delivered at the Chicago Polyclinic by that eminent Chicago oculist, Dr. F. C. Hotz: "Gentlemen, it is the fact that the severe neuralgic pain, and the violent gastric disturbances, induced by acute glaucoma, have been taken and treated for "rheumatic or malarial" neuralgia, while the ocular disease has not been recognized until too late. I have seen several cases of this mistake; one was an especially sad case which

impressed me so much that I shall never be able to efface its picture from my memory. Though fifteen years have gone by since I have seen the unfortunate patient, her image is before me now as vivid and distinct as if I had seen her yesterday. Two months before I saw her she had been seized with fever, nausea, frequent vomiting, and violent pain extending over the entire left side of the head. Her physician pronounced her trouble to be gastritis, and "sick headache," and when the old lady called attention to the fact that her sight was getting poorer every day (and she could see with her left eye only; for the sight of the right eye had been destroyed by glaucoma ten years) he assured her she need not worry about it; that her sight would return as soon as the stomach trouble was cured, and the neuralgia in the head relieved. Having implicit confidence in her physician she believed his word, and though her sight soon had vanished completely, she waited hopefully for the day when the darkness would be lifted again from her eyes, and patiently endured the constant, most violent headache, which robbed her of rest and sleep by day and night. For two weary months this poor woman suffered and hoped; but then her patience was exhausted and much against the will of her physician she went to consult an oculist. Poor woman! it was too late. The continued high tension of glaucoma had done its deadly work upon the optic nerve too truly, and although the iridectomy effectually reduced the intra-ocular tension, and promptly relieved the patient of the terrible headache so that after the operation she could enjoy a good quiet sleep for the first time in



eight weeks, the woman has never seen a ray of light since the awful result of a mistaken diagnosis."

#### INCREASE OF ALCOHOLISM IN EUROPE.

We are continually reminded by the official statistics of those countries in Europe which have been considered as models in regard to the temperate use of alcoholic beverages, that the tendency is ever toward the use of stronger drinks. The *Lancet*, June 24, says: In southern and central Europe particularly, where the conditions of climate and race render the human subject less tolerant of alcohol than further north, its increased consumption and disastrous consequences have provoked against it a crusade whose leaders can point to even stronger justification than the paladins of the same movement in the British Isles. Amongst the Latin peoples the multiplication of homicides due to alcoholic stimulus is a fact confirmed over and over again by statistics and verified by medico-legal experts. It was bad enough when the new and fiery "wine of the country" was taken to excess, but the growing consumption of spirits, generally of the worst quality, which in the last decade has crept into the nationalities bordering on the Mediterranean, has raised crimes of blood to a figure perfectly appalling. Switzerland, exemplary in so many ways to the rest of Europe, forms no exception as regards the wide-spreading habit, and already an organized attempt to correct if not stamp out the same has for some time been on foot. At the head of the movement is the eminent alienist of Zurich, Dr. August Forel, professor of psychiatry in that medical school, well known

as an accomplished and philanthropic physician in every department of State medicine.

#### POISONING BY CHLORATE OF POTASSIUM.

At a recent session of the Montreal Medico-Chirurgical Society Dr. Johnston (*Canada Med. Record*) related the following case:

The patient, a boy aged 10, on December 14th, on getting up in the morning had a sore throat and did not feel well. He went to work, but during the day he felt so ill he returned home, and his mother, thinking that he had quinzey, gave him a solution of chlorate of potassium to drink. The amount taken during the day was nearly two tumblersful of a saturated solution, equal to about six drachms of the salt. In the evening Dr. J. A. MacDonald was called and found the boy in a dying condition, with intense cyanosis of the face and extremities. The autopsy was performed at the order of the coroner. All the conditions indicated that death was caused by the potass. chlorat. This salt destroys life by decomposing hæmoglobin into methæmoglobin. There were two ecchymotic spots, one on the inner surface of the left forearm and the other on the anterior surface of the right leg. On incision they were found to be due to extravasated blood of a dark coffee-brown color and sticky consistency, and which did not change color on exposure to air. The blood removed from the heart showed the characteristic appearances of methæmoglobin; it was thicker than normal, of a peculiar chocolate-brown color. The kidneys, spleen, lungs, bone marrow, and brain showed the characteristic brown coloration; urine



contained a large amount of albumen but no blood or methæmoglobin. Spectroscopic examination of diluted blood gave deep absorption bands at C and F, in addition to two paler bands at D and E, which are characteristic of hæmoglobin.

The appearances might be mistaken for those found in acute infectious fevers, or poisoning by other substances which produce methæmoglobin, but here chemical analysis showed a large quantity of potass. chlorat.

#### POISONING FROM CODEINE.

Dr. Spratling reports (*Med. Rec.*, July 15,) the following case:

Shortly after 10 o'clock on the evening of June 8th I was requested to see a young married woman who had taken an overdose of codeine. Immediately after dinner, about 7 o'clock in the evening, she had taken sixteen half-grain pills, making eight grains altogether. She had suffered for some months from a painful disease, and had been ordered by her physician to take codeine in quarter-grain doses for the relief of pain, and to overcome a persistent insomnia. Not deeming the quarter-grain doses of sufficient strength, the patient then procured from the druggist a vial labelled as containing one hundred half-grain codeine pills. Three hours before my visit she had swallowed sixteen of these, as she avowed, for the purpose of securing a good night's sleep. An hour later she experienced considerable nausea, and vomited a small quantity of semi-liquid matter. I found her awake, able to converse perfectly well, but extremely restless and irritable. She could not lie in one position, but constantly changed

it by tossing, almost violently, from side to side of the bed. At frequent intervals she would manifest convulsive movements involving the entire voluntary muscular system. These movements were most marked in the upper extremities and the head. She suffered greatly from intense irritation of the skin over the entire body. This irritation was most annoying along the flexor surfaces of the forearms and on the back. She had an attendant rub her back so vigorously with a coarse towel that the skin in many places was broken. The surface of the body was warm and dry. The pupils were fixed in pin-point contraction. Respirations were twelve per minute. She complained of great thirst, and an uncomfortable feeling of fulness in the head. I endeavored to ascertain by repeated questioning whether she experienced any of the pleasant mental effects that follow the exhibition of morphine, but failed to find that such was the case with her at any time during the action of the drug. She frequently remarked that her "thoughts were going round and round." After the painful irritation of the skin been relieved by sponging the body with solution of bicarbonate of soda, she sank into a light doze, from which she would awake in a few minutes with a start. The skin was hyperæsthetic to a marked degree. She was subjected to the usual treatment for opium-poisoning, and in a few hours was much improved.

By noon on the following day she had fully recovered from the effects of the drug in every way, save that considerable muscular weakness remained. We apparently have no fairly accurate knowledge as to what amount of this drug may be regarded as a fatal dose.

## TREATMENT FOR SPRAIN.

In the *International Medical Magazine*, July, Dr. Gibney draws attention thus to a method advocated by Mr. Cotterill, London. He says: Physicians often talk in a vague way about ruptured ligaments in sprains, but as a rule the ligaments are not ruptured. What really happens is, that the tendons and the capsule of the joint are strained. When such an accident occurs, there is ecchymosis and swelling, the fluid in the sheath of the tendon becomes increased, and we have all the usual signs of acute sprain. After you have excluded fracture and dislocation, proceed to treat the sprain properly in the following simple manner: Put the injured foot on an inclined plane, or tell the patient to lie with the foot upon the head of a sofa for some time, while some one carefully and patiently rubs the injured tendon. After a few hours of rest, straps of adhesive plaster should be applied like a Scultetus bandage, beginning below the seat of injury and continuing up two or three inches above the injured area. Over this a piece of cheese-cloth is applied for the first night, and a light bandage. As soon as the bandage is applied, let the patient put on the shoe and insist on his beginning to walk in your presence. After the first few efforts it will be comparatively easy. Never allow these patients to use crutches, and never be guilty of using plaster of Paris or a fixed dressing. If the toes show a tendency to swell, they should be strapped first. After about a week, fresh plaster should be put on. I first adopted this treatment five or six years ago, and I have

treated sprains that way ever since, and have never felt that I have made a mistake in so doing. Quite recently I have treated chronic sprains by giving the patient ether, and producing a condition simulating an acute sprain, and so far with fairly good results.

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**Medical Items.**


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The washing of the parts with ether is said to be a rapid and complete method of destroying pediculi pubis.

Today, one of the most important and at the same time one of the most neglected branches of a medical education is sanitary science.

Dr. Hodgers, of Wilmington, one of the editors of the *North Carolina Medical Journal*, has accepted the chair of Anatomy in the College of Physicians and Surgeons, in the new college recently organized in Richmond.

Dr. Thomas J. Moore has been elected to the chair of Clinical Medicine in the College of Physicians and Surgeons of Richmond. Dr. Moore is originally from Charlotte, N. C., and this college is to be congratulated upon its wise selection.—*Ex.*

Quite a sensation has recently been made in Boston by the successful application of wool-fat, or agnine, to the skin, for the removal of wrinkles. When applied with rubbing, it passes directly through the skin and acts as a nutrient to the fatty tissues beneath. An ancient dame has succeeded in removing nearly all the crows-feet from around her tem-

ple, and the remedy is fast becoming very popular.—*Medical and Surgical Reporter*.

In Madrid, Spain, there is surely the most unique operating theatre in the world. In their wild endeavor to keep out the deadly microbe, those who constructed it provided an immense glass cabinet in which the patient, the operator and assistants and instruments are confined. The spectators witness the operation from the outside. This is nothing but "transcendental antisepticism and monumental nonsense." At present, antiseptic precautions seem to be heading towards simpler methods instead of the more complicated.—*Atlanta Medical and Surgical Jour.*

The *Ohio Medical Journal* says: "The honest man cares but little whether there be a law or not, except for its restraining influence over those who might do him harm. When, therefore, a man or a journal sets up a howl against the Code of Ethics, it reflects very seriously upon the morality of the howler. If the medical profession is antiquated because of its code, then may the same criticism be urged against all forms of government—a criticism that appeals only to the anarchist. Let him who is opposed to the Code of Ethics go where he belongs—outside."—*Ex.*

The following appears at the foot of a bill-head of a Kansas physician. It is unique, original, and pointed, and we presume effective: "A prompt settlement of this bill is requested. If bills are paid monthly, a discount of ten per cent. is given. Bills not paid monthly will be passed to my attorney for collec-

tion. If you pay your physician promptly he will attend you promptly night or day, rain or shine, while your slow neighbor suffers and waits, as he made the doctor wait, and while he is waiting the angels gather him in."—*Kansas Medical Journal*.—*Med. Rec.*

The American Medical Editors will have a meeting and banquet in Washington on the evening of Monday, Sept. 4th, the day preceding the assembling of the Pan-American Medical Congress. Dr. I. N. Love, of the *Medical Mirror*, 3642 Lindell Avenue, St. Louis, has been appointed Chairman of the Committee of Arrangements for Banquet, which fact gives ample assurance of the success of the latter.

It is earnestly hoped that every medical editor of all of the Americas will endeavor to be present on the interesting occasion. Please address the Chairman of Committee of Arrangements promptly.

A new edition of Dunglison's Medical Dictionary is announced as in press for early publication. It has been thoroughly revised and greatly enlarged, and will contain about forty-four thousand new medical words and phrases. Pronunciation has been introduced into the new edition by means of a simple phonetic spelling. This work has always been noted for the fulness of its definitions, ample explanation being its distinguishing characteristic. In the new edition much encyclopædic information, difficult of access elsewhere, will be found conveniently at hand. Especial attention has been devoted to matters of practical value. A review will appear in an early issue of this JOURNAL.



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## Original Articles.

### FRACTURES OF THE PATELLA; TREATMENT.

BY I. R. TRIMBLE, M. D.,  
OF BALTIMORE.

Surgeon Baltimore and Ohio R. R. and Baltimore and Lehigh R. R.; Professor of Anatomy and Clinical Surgery in the Woman's Medical College; Lecturer on Clinical Surgery in University of Maryland School of Medicine.

Fractures are produced in two ways:

- I. Muscular action (indirect violence).
- II. Direct violence.

In breaks of I, the line of fracture is generally transverse, and most often the seat of fracture is across the lower third of the bone.

As the knee is generally slightly flexed when a person slips, the centre of the

patella rests between the condyles of the femur, with the lower and upper parts unsupported; now a sudden contraction of the quadriceps extensor muscles is apt to break the patella at its weakest point, which is at the lower third.

After a transverse break, if the fibres of the muscles inserted into the sides of the patella continue to act, the upper fragment may be split in a vertical direction.

II. By a blow or a fall on the patella. In the last instance the leg must be slightly bent, otherwise the tuberosity of the tibia would strike the ground first. There is always muscular action combined with direct violence, and if the dense fibrous tissue over the patella is ruptured the fragments are widely separated by the muscles attached to the sides of the patella.

Fractures by direct violence are generally stellate.

If the dense fibrous tissue over the patella is not ruptured, then there is slight separation of the fragments.

The bones entering into the knee-joint are the condyles of the femur above, the head of the tibia below, and the patella in front.

The coverings of the knee-joint are, skin, areolar tissue, prepatellar bursa, the tendons of the quadriceps extensor muscles, with the sesamoid bone, the patella, in the tendon, the ligamentum patellæ, which runs from the lower end of the patella to the tubercle of the tibia; the most superficial fibres of that tendon run over the surface of the patella and join those of the tendon of the quadriceps extensor.

Dense fibrous tissue and periosteum cover the front of the patella.

Back of the patella is the knee-joint. The capsular ligament joins the upper border and sides of the patella.

In every case of fracture of the patella we have extravasation of blood into the knee-joint.

If the prepatellar bursa, when present, is in the line of fracture, its posterior wall will be ruptured, and the bursa opened into the joint.

When there is a transverse tear of the capsule with the break, the fragments are more widely separated; some of the other things which facilitate the separation of the fragments are extravasation and clotting of blood in the joint, opening of the bursa, threads of tissue, and at times the skin itself is driven between the fragments of bone. There is always tilting of the fragments of bone in various directions, from the insertion of the

tendon of the muscles with the anterior edge of the bone. The muscles continuing to act, pull the fragments further apart and evert the edges.

Seldom is a person able to move or stand on the leg after the patella is broken. There is always loss of power, with more or less swelling and pain. Unless bony union of the broken patella takes place, there is no certainty of a useful leg; this union is only possible when the broken parts are brought and kept in direct apposition.

The result from a fibrous union between the fragments of bone is only fairly good, if we are lucky enough to get a dense fibrous band between the fragments, not over one-half inch long, and which does not stretch after using the limb.

Vertical fractures usually heal by bony union.

In direct violence the skin is often badly contused, and sloughing is apt to occur, especially if there is much tension in the joint, which by mechanical pressure cuts off the life of the tissues around the joint.

When the periosteum tears it is as a rule on a different level from the broken bone and the free edge of the periosteum falls over the broken edge of the fragments.

*Treatment.*—All the text-books spend page after page in extolling the virtues of the various appliances for keeping the broken fragments together, and say only a few lines about operative treatment, and this is never advised unless there is a compound fracture of the patella; then under the strictest antiseptic precautions we are to wash out all foreign matter from the joint and bring the fragments into apposition with wire or silk.

Now in the cases where the fracture is not compound we have a disorganized joint with the fragments of bone separated by materials foreign to the joint, the edges of bone overlapped by fibrous tissue.

If the fracture is comminuted some loose bone is apt to be free in the joint and will give rise to future trouble if left alone.

By all the various appliances we are neverable to get bony union of the fragments and unless we have bony union, we can not be certain of getting a good result. Hamilton, on Fractures and Dislocations, page 436, says: "I do not know positively that in any case the union was by bone. If I were to state my convictions, I would say that probably none of the tabulated transverse fractures were united by bone and that only a small proportion of the vertical and commuted fractures were thus united. I do not deny the possibility of union by bone. A few cases, verified by the autopsy, have been reported from time to time, but I have seen but one case verified by dissection.

Bony union was for a long time considered impossible. Pibrac challenged all surgeons of his time to show him a patella thus united.

Dupytren, who thought he had obtained a union of this kind, offered for the patella of his patient its weight in gold. According to Velpeau, however, Wilson and C. Bell had seen a case of bony union, Lallemand had demonstrated its possibility and there was a specimen of it in the Hunter Museum.

The various appliances to keep the fragments in position are useless and at times dangerous, for suppuration of the

tissue around and in the joint has occurred by their use.

The only way to get bony union is to lay open the joint, clean out the foreign matter and suture the fragments in direct apposition.

Surgery of to-day enables us by a strict antiseptic operation to open and wash out all the foreign matter from the joint and bring the fragments of bone in apposition and keep them there either by means of silver wire through the fragments or by suturing the dense connective tissue over the fragments, in this way ensuring the permanent coaptation of the broken edges to broken edges. It seems, as far as the result of a bony union is concerned, to make no difference whether wire or silk is used to keep the fragments together.

The joint is then closed and a bony union and good joint is the result. But if pus forms in the joint after operation, the surgeon can be certain that he has not done a clean operation and the fault is his, not the patient's.

CASES.—A stevedore, German by birth, age 35. 6 P. M., June 11, 1891, fell from the side of a steamer into a scow 20 feet below the steamer's deck, striking on his left knee. I saw him at 7 P. M., June 11. Left knee much swollen and skin discolored, comminuted fracture of patella and fragments widely separated. Leg useless, pain on movement of the knee.

The leg was scrubbed with a stiff nail brush, hot water and green soap, shaved and put up in a wet 1-1000 bichloride of mercury dressing until the next day.

June 12, leg scrubbed, washed and shaved, as on June 11. Man put under



ether, leg covered with a sterilized sheet, only the knee being exposed. A transverse incision made over center of the knee and joint freely opened; clots of blood and some loose fragments of bone were washed out with warm water which had been boiled. After that a warm 1-8000 bichloride of mercury solution was used in the joint. The capsule was torn transversely; there were three upper fragments of the patella and one small lower fragment; all were widely separated and tilted out of position and the torn fibrous tissue lay loosely over the broken edges.

The upper fragments were wired together and then wired to the lower fragment; the transverse tear in the capsule was sewed loosely together with sterilized silk; the loose fibrous tissue sewed over the broken patella with sterilized silk sutures and the skin was then sewed loosely together with sterilized silk. A sterilized dressing applied and leg put on a well padded board splint from buttock to below the heel.

June 12, T. 101, P. 86, R. 16.

June 13, T. 98, P. 72, R. 16.

The temperature after this remained normal. June 20, dressed the knee and removed skin sutures; the wound had healed. Then put leg in plaster splint from buttock to foot. Man allowed to get up and go on crutches.

August 1, cut off splint and did passive motion. A knee splint reapplied and every second day did passive motion.

September 1, 1891, left off splint. October 12, 1891, man returned to his former work and has been at it ever since. August 15, 1893, the union is bony, motion of joint perfect and as strong as ever.

May 7, 1893, 10 P.M., a carpenter, age 56, German, walking across floor, slipped and fell backward, and in recovering his balance felt something snap in his right knee; he fell to the floor and was unable to move his right leg. May 8, 1893, 10 A.M., I saw him. Knee swollen, skin dark from extravasated blood, leg useless; a transverse fracture of the patella at lower third, upper fragment separated  $5\frac{1}{2}$  inches from lower fragment when the knee was flexed.

Leg scrubbed with a stiff nail brush, hot water and green soap, shaved and put in a wet bichloride solution 1 to 1000. In the evening of May 8, the man was etherized. Leg was scrubbed as before and washed off in a bichloride solution. A vertical incision six inches long made over the middle of the joint. The blood-clots turned out and the knee thoroughly cleaned with warm water which had been boiled and then irrigated with a 1 to 8000 bichloride of mercury solution.

The capsule was torn transversely, fragments widely separated and tilted out of position; the loose fibrous tissue covered the broken edges of the bone. The fracture was transverse and the posterior surface was fractured at a higher level than the anterior surface.

The fragments of bone were brought into position and held there by suturing the torn fibrous tissue together with sterilized silk.

The transverse tear of the capsular ligament was sewed up loosely and the skin was brought together with a continuous suture. Sterilized dressing applied and the leg put on a long posterior splint.

May 16, the incision had healed and

skin sutures removed. Put the leg in plaster from foot to the buttock.

June 25, took off the splint and began passive motion. Put the knee in another splint. Every two days removed splint and did passive motion. July 3, motion was almost perfect. Good bony union of the patella. He returned to work July 20, and has been at work ever since. August 20, his leg gives him no trouble.

In both of these cases bony union would have been impossible without an operation. In all cases of fracture of the patella with any separation of the fragments, open and cleanse the joint and bring the fragments together with either wire or silk sutures.

The vertical incision of skin is better than the transverse incision, for there is less liability of the separation of the cicatrix when passive motion is begun. After the leg has been in plaster for two or three weeks the patient can get around on crutches. By this method we get bony union of the patella and a good and useful joint with the minimum loss of time and discomfort to the patient.

When the wound is compound, cleanse thoroughly, bring the fragments together and sew up loosely.

The things to be remembered are a clean aseptic operation, a long incision, to prevent laceration of the skin in cleansing the joint, keeping the fragments together, put in a stiff splint at first and begin passive motion early.

214 W. Franklin Street.

The medical profession of Havre recently gave a dinner in honor of a physician of that place who was born April 4, 1793.—*N. C. Med. Jour.*

## REPORT OF A CASE OF BEZOLD'S VARIETY OF MASTOID DISEASE.\*

BY WILLIAM J. TAYLOR, M. D.,  
Surgeon to St. Agnes Hospital; Assistant Surgeon to  
the Orthopaedic Hospital and Infirmary for  
Nervous Diseases.

The following case was admitted into the surgical ward of St. Agnes Hospital on the evening of May 1, 1892.

Henry M., aged twenty-five years, and unmarried. Family history was very good. Some seven years before, he suffered from "a running" from the right ear which lasted for only two or three days. It received no treatment, but got well of itself, and from that time until the beginning of the present illness he has had no further trouble. About Christmas-time, a little over five months before his admission into the hospital, he had an attack of something resembling "la grippe," accompanied by sore throat of a mild type; from this illness he also recovered rapidly.

The present illness began about the 30th of March, with pain in the right ear and headache. This pain persisted, and in about two weeks it centred in the ear.

He was then treated for over two weeks as an out-patient at the Medico-Chirurgical Hospital. He became much worse and was confined to his bed.

The day before his admission into the hospital he was seen by Dr. O'Hara, who, with the aid of Dr. Brinkmann, made an incision over the mastoid region. They could find no perforation or necrosis of the bone, and on account of the gravity of the case and because he could not receive proper care and

\*Read before the Philadelphia County Medical Society.

nursing at home, he was sent immediately to St. Agnes Hospital. Upon admission his condition was one of pronounced septic poisoning, and when I saw him the next morning I feared the process had extended to the lateral sinus, and possibly to the cerebral tissues. His mental condition was dull and his vitality much depressed. The temperature was 100°F., and the pulse weak and very rapid. There was paralysis of the right facial nerve, but no evidences of cerebral motor disturbance. As it was plainly to be seen that delay would be dangerous, he was placed under the influence of ether at once. There was much swelling and œdema over the right mastoid region, which extended downward into the neck, quite to the upper border of the clavicle. The skin of the neck was much reddened and congested. Pus was seen coming from the incision which Dr. Brinkmann had made behind the ear, and from the external auditory meatus. This incision was enlarged and the bone exposed and found to be hard and white, but pus was seen coming from below and from the direction of the auditory canal. The incision was extended downward into the neck, across the tip of the mastoid process, and over the sterno mastoid muscle. This liberated a large quantity of pus. The tip of the mastoid process was now found to be necrosed, and the whole medial surface of the process was softened and broken down. A probe, and afterward a curette and the finger, could be passed from the inner or medial side into the centre of the mastoid antrum.

The posterior wall of the auditory canal was now chiselled through and the middle-ear cavity curretted with care but

great thoroughness, and a large amount of cheesy pus removed.

The pus had burrowed into the digastric fossa and then down the neck beneath the sterno mastoid muscle and along the tract of the great vessels.

All of the mastoid process which showed evidence of necrosis was carefully removed by means of the chisel and curette, and the whole wound thoroughly disinfected. The deep wound in the neck was drained by means of large rubber tubing, and was packed with iodoform gauze. As I did not have at hand rubber tubing of proper size, I passed a bundle of horsehair down through the external auditory meatus into the middle ear, and out through the wound in the mastoid process, thus insuring free exit for all pus. The remainder of the wound and auditory meatus was packed lightly with iodoform gauze.

An ample dressing of bichloride gauze was now applied, covering the whole side of the head and neck, and the patient placed in bed. I feared, as previously stated, that cerebral abscess or other extension of the septic process had already occurred, but my dissection had been so extensive and the operation so prolonged that I thought it best to wait and see if further operative measures would be necessary.

His general condition by this time was grave and the shock was most profound.

The improvement in his symptoms manifested itself almost immediately. Reaction from the effects of the operation was somewhat slow but sure. His progress toward recovery was from this time rapid and without special interest. Within a few days the drainage-tubes and horsehair were removed, and the



wounds which had not been closed by sutures were packed gently with iodoform gauze to insure free drainage, and a generous bichloride gauze dressing was applied over the whole side of the head.

On the seventh day his temperature had reached the normal, the highest point being  $100\frac{3}{4}^{\circ}$ , and this on the day following the operation, and remained so from that time out. For a long time, however, his heart was extremely weak. No valvular lesion could be detected, but the pulse was very weak and very rapid. There was also a difference in volume between the radial pulse-beats.

Under the free administration of tonics, stimulants, and good food, he rapidly improved in health and strength, and was discharged from the hospital, July 14, well.

The facial paralysis persisted, however, This gradually improved, but up to the date of his discharge from the hospital his inability to close the upper eyelid was very apparent. The uvula was paralyzed on the right side, and the sense of taste diminished on the right side of the tongue as well.

His general health was very fair, though he still showed in his appearance signs of the severe illness through which he had passed.

On October 5th he was examined by Dr. Isaac Barton, who sent me the following report:

"I find evidence of a ruptured membrane, possibly for the escape of pus from his right side. The membrane now has partially re-formed, and his hearing with the watch on the right side normal. The 'A' tuning-fork is heard at five inches on the right side, while on the left it is normal.

"Bone conduction on the right side is very poor with the 'A' and 'C' tuning-fork, being the result of the operation and previous condition of the mastoid cells (of the right side). Nasal passages, anterior and posterior, somewhat congested but free for breathing space. Eustachian orifice of left side normal, that of the right side much thickened but not occluded."

In December, Dr. O'Hara called me to see him in consultation, as symptoms of typhoid fever were present. By this time the facial paralysis was entirely relieved, but he passed through a typical attack of typhoid fever. He had several hemorrhages from the bowels, and in the course of a few weeks periostitis of both shin bones developed. Suppuration occurred. Dr. David Bevan very kindly made a bacteriological examination of some of the pus and reports *staphylococcus pyogenes albus*.

#### COCAINE.

In using cocaine, remember the following propositions:

1. Cocaine may be toxic.
2. This effect is not rare.
3. There is a lethal dose of cocaine.
4. This dose is uncertain.
5. Dangerous or deadly results may follow doses usually deemed safe.
6. Toxic effects may be the sequence of doses large or small, in patients young or old, the feeble or the strong.
7. The danger, near and remote, is greatest when given under the skin.
8. Cardiac or renal weakness increases the risk.
9. Purity of drug will not exempt from ill result.
10. Caution is needful under all conditions.—*Dental Cosmos*.

## MARYLAND MEDICAL JOURNAL.

A Weekly Journal of Medicine and Surgery.


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BALTIMORE, AUGUST 26, 1893.

### Editorial.

#### AFTERNOON LOUNGINGS.

It is too hot to work—so it is. But it is hotter still to do nothing.

The citizen who can devise a pleasant absorbing occupation for August afternoons deserves a monument.

Here is a receipt: Let the doctor cooped up in the city give orders to his servant that he is to be called only in case of necessity. Let him then, with a pitcher of some refreshing temperance beverage, retire to his own room, divest himself of all unnecessary garments, stretch himself upon his couch or bed, and, with a pad of paper and a fountain pen, amuse himself by jotting down incidents from medical experience.

You know short stories are all the rage now in magazines of general literature. The author who can start a man and woman into life, get them engaged, jilted, exiled, attacked by bandits, rescued, re-engaged, married and interred in

a space of ten printed pages, without a jar or squeak of his machinery, has made his fortune as a magazine writer.

It seems as if the short medical article were to be "the thing" in the near future. Instead of long elaborate padded disquisitions or narratives, the eye will be caught by vivid, terse, artistic word-etchings of rare cases or well-studied collections of symptoms. Not long stories of irrelevant details; but chosen bits of case-scenery, brought out by master-pens into clear relief.

This will make the medical journal interesting; for among all the dry things in the world the medical journal of the present day is the most arid.

Occasionally some old fellow will tell something in a cheerful way about his early experiences; but the average writer seems to have lost all sense of humor and to be wholly insensible to those qualities of things which render life endurable. Medicine has been lost in science. Medical literature is overwhelmed and the life is crushed out of it by the grimness, the baldness, the insipidity of science. The older physician, who cannot write about the latest bacteria or the ultimate pathological changes of the disease which he has skillfully combatted, fears to write at all. The young practitioner waits until he is gray-headed before he dares to pen an account of a successful method of treatment which he has devised.

Through the vista of the future we look forward to the time when the varied literary gifts of medical men shall all find expression in the medical journal. When poetry, travel, philosophy, fiction, illustration shall enliven the dryer details of laboratory records and clinical

reports. When rich corporations of professional men shall obtain, in return for respectable sums of money, the best specimens of medical literary production for first class medical monthlies.

In the meantime, gifted reader, as you stretch yourself on the aforesaid August afternoon upon your couch or bed, as aforesaid, let us exhort you, having the fountain pen in hand, to divert your attention from the fatiguing consideration of atmospherical torridity by sketching in words some of the scenes through which you have passed during by-gone months. Not, like the small boy who spoiled his sketch of the dwelling house by trying to depict each potato-vine in the garden before it; but in bits, in glimpses, such as you would give a medical friend by the fireside of a winter night. Put a pinch of your own individuality into the recital; and then—send it to the JOURNAL and see how your friends congratulate you upon it.

And you will have forgotten that it is an August afternoon.

### IRON IN CHLOROSIS.

The fact of the pre-eminent value of iron as a remedy for anæmic conditions is thoroughly established; the mode of its action is still a matter for dispute. Under a course of iron the quantity of iron in the red blood corpuscle and the number of these corpuscles undoubtedly increases in favorable cases. But whence does this iron come? From the iron administered? Or from the iron of the food? Does the iron administered yield ferruginous matter directly to the corpuscles of the blood? Or does it simply improve the condition of the digestive

canal, so that more of the organic iron of the food is taken up by the corpuscles? If the latter is the fact, then may not other drugs having similar and even more intense action upon the digestive canal, be of still greater value than iron in anæmic diseases? With a view to the solution of some of these problems an instructive series of investigations has been made by Dr. Stockman, as reported in recent numbers of the *British Medical Journal*.

His first effort was to determine the influence of iron administered subcutaneously upon chlorosis. For, if it is well-marked, it will be evident that the chief benefit of iron as ordinarily given is not obtained through local action upon the digestive canal. In four cases of chlorosis treated by hypodermatic injection of iron salts, very rapid improvement was observed, as shown both by microscopic examinations of the blood and by the general appearance and sense of well-being of the patients. The salts of iron thus used were the peptonate of iron and the citrate of iron and sodium; these were dissolved in water, the dose being  $\frac{1}{2}$  grain, or more commonly  $\frac{1}{4}$  grain, in each daily injection. Improvement was as marked as if large doses had been taken by the mouth.

None of the patients ever objected to the injections, which were made into the thick tissues of the back, and produced no disturbance other than a slight local hardness. The dose, however, is necessarily small, even  $\frac{1}{2}$  grain of iron causing in one case nausea and colic. As iron can usually be comfortably taken by the mouth, its hypodermatic use, except in special investigations, is not recommended.



In his further clinical experiments the influence of bismuth oxide, subnitrate, and salicylate; of arsenic; of manganese binoxide and sulphate; and of muriatic acid was successively tested in cases of anæmia (chlorosis), but no marked benefit was observed.

Dr. Stockman finds that the organic compounds of iron are much less efficient than the inorganic. Moreover, a rich and varied diet, containing plenty of organic iron, does not ordinarily cure a patient. Inorganic iron must be combined with it.

The ferruginous preparations made from blood (such as "hæmol" and "hæmogallol") gave likewise no beneficial results.

It should be remembered, in conclusion, that women have normally less hæmoglobin (and so, less iron) in the blood proportionally than men.

"No proof has yet been given," says Dr. Stockman, "that any one inorganic preparation of iron cures chlorosis more quickly than another."

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### Reviews, Books and Pamphlets.

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*Nursing; Its Principles and Practice for Hospital and Private Use;* by ISABEL ADAMS HAMPTON, Graduate of the New York Training School for Nurses, Bellevue Hospital; Superintendent of Nurses and Principal of the Training School for Nurses, Johns Hopkins Hospital; Late Superintendent of Nurses, Illinois Training School for Nurses, Chicago. Illustrated. Small 8vo., pages 484. Price \$2, net. Philadelphia: W. B. Saunders, 925 Walnut St., 1893.

The book before us presents an excellent directory for nursing as it is done in the best American hospitals. With such wide experience in three of our great medical centres, and with such high standing in her profession as is indicated by the posts of responsibility to which she has been called, we may be sure of the thoroughness of the author's knowledge of her theme. In addition to this we find from perusal of her work that she is equally skillful as a writer; presenting her subject in a clear, concise manner; and exhibiting that most desirable of all traits in a teacher, the ability to follow the newest and most advanced methods with due respect to broad and judicious conservatism.

We recommend the book most highly, and congratulate its author upon her successful literary effort.

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### Pan-American Congress.

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#### PRELIMINARY PROGRAM OF THE SECTION ON OPHTHALMOLOGY.

To be held in Washington, D. C., September 5, 6, 7, and 8, 1893. The meeting of the Section will be held in the Arlington Hotel. The session of September 6th will be devoted to the discussion of the subject of the Detection and Correction of Astigmatism, with the reading of papers upon this subject. The meeting of September 7th will in like manner be given to a consideration of the Detection and Correction of Muscular Errors. Julian J. Chisolm, M. D., Executive President, Baltimore, Md.; George M. Gould, M. D., English-speaking Secretary, Philadelphia, Pa.; J. Harris Pierpoint, M. D., Spanish-speaking Secretary, Pensacola, Fla.

SEPTEMBER 5TH, THREE O'CLOCK P. M.

"Some Experiences in Haemorrhagic Glaucoma: Its Progress and Treatment." By Dr. S. D. Risley, Philadelphia.

"Homeochronous Hereditary Optic-nerve Atrophy Extending Through Six Generations." By Dr. Geo. M. Gould, Philadelphia.

"Suppurative Processes of the Vitreous." By Dr. J. F. Fulton, St. Paul.

"A Clinical Study of the Visual Field in Hemianopia." By Dr. Chas. A. Oliver, Philadelphia.

"Glaucoma from Traumatic Causes." By Dr. E. Lopez, Havana.

"Spontaneous Replacement of a Case of Detached Retina." By Dr. J. Wallace, Philadelphia.

"Etiology and Early Management of Glaucoma." By Dr. G. E. Dean, Scranton, Pa.

"Acute Monocular Neuro-retinitis, with Cases." By Dr. B. L. Millikin, Cleveland.

"Cataract Extraction with Iris Retractor, with Report of Twenty-nine Cases." By Dr. Francis Valk, New York.

SEPTEMBER 6TH.

"Further Studies of the Cycloplegic Value of Homatropin and Cocain Discs as a Substitute for Atropin and Hyoscyamin." By Dr. Casey A. Wood, Chicago.

"The Relation of Skiascopy to other Tests for the Determination of Ocular Refraction." By Dr. H. V. Wurde-  
mann, Milwaukee.

"The Necessity for Complete Suspension of Accommodation by Mydriatics in the Adjustment of Glasses." By Dr. G. C. Savage, Nashville, Tenn.

"A Contribution to Refractive Errors." By Dr. J. C. Morgan, Philadelphia.

"The Hygienic and Scientific Value of Examinations of the Eyes in Schools." By Dr. B. A. Randall, Philadelphia.

"Refraction Anomalies of Artists." By Dr. J. C. Morgan, Philadelphia.

"Astigmatism following Cataract Extractions and other Sections of the Cornea." By Dr. Edward Jackson, Philadelphia.

"A Few Thoughts about Ophthalmometry, as to What the Javal Instrument Will Do and What it Will Not." By Dr. Louis J. Lautenbach, Philadelphia.

"Skiascopy in Ophthalmometry." By Dr. Pedro Lagleyze, Buenos Ayres, Brazil.

SEPTEMBER 7TH.

"A Clinical Study of Heterophoria." By Dr. Hiram Woods, Baltimore.

"An Analysis of Fifty Cases of Internal Squint." By Dr. H. F. Hansell, Philadelphia.

"Some Forms of Anomalies in Eye Muscles." By Dr. E. J. Gardner, Chicago.

"Affections of the Nose as a Cause of the Want of Concordance of the Action of the Eye Muscles." By Dr. W. Cheatham, Louisville.

"Further Experiences in Graduated Tenotomy." By Dr. Charles H. Thomas, Philadelphia.

"Graduated and Complete Tenotomy for the Relief of Heterophoria, with a New Objective Test for Use During Operation." By Dr. S. Lewis Zeigler, Philadelphia.

SEPTEMBER 8TH.

"Treatment of Six Cases of Irido-cyclitis Complicated with Cataract." By

Dr. Robert L. Randolph, Baltimore.

"Electric Therapeutics in Ophthalmic Practice." By Dr. L. A. W. Alleman, Brooklyn.

"Gouty and Rheumatic Affections of the Eye." By Dr. W. Oliver Moore, New York.

"The Local Application of Bichloride of Mercury in the deep Inflammations of the Eye." By Dr. W. F. Mittendorf, New York.

"Skin-grafting for Malignancy of the Eyelids." By Dr. F. B. Tiffany, Kansas City.

"The Nomenclature of Blepharitis." By Dr. Dudley S. Reynolds, Louisville.

"Orbital Tumors." By Dr. W. B. Johnson, Paterson, N. J.

"Exophthalmus Traumaticus." By Dr. L. F. Love, Philadelphia.

"Further Observations on the Eye of the Negro." By Dr. C. W. Kollock, Charleston, S. C.

"Hæmorrhage or Croupous Iritis." By Dr. A. Alt, St. Louis.

"A Case of Cysticercus in the Vitreous." By Dr. W. Cheatham, Louisville, Kentucky.

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#### MEDICAL PUBLISHERS TO ORGANIZE IN WASHINGTON SEPTEMBER 5TH.

For several years past strenuous efforts have been made to organize an association beneficial alike to both medical publishers and legitimate advertisers, but since the success of such an organization depends largely upon the universal co-operation of the publishers of medical journals little has, heretofore, been accomplished. We learn, however, with pleasure, that while the Pan-American

Medical Congress is in session on September 5th, there will also be assembled in Washington, publishers of medical journals from all over the country, for the purpose of framing such laws governing medical journalism as will result in their mutual benefit. As this association will not in any way conflict with the Editors' Association now existing, publishers and particularly editors who are also publishers of medical journals should feel it their duty to aid by their presence and co-operation such a movement. We heartily endorse the aim of the association as we understand it, and shall surely do our best to bring about a culmination of the efforts now being put forth.

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#### Medical Progress.

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##### MECHANICAL TREATMENT OF HABITUAL CONSTIPATION.

Dr. Beatty, a surgeon of the British Navy, affirms the success of the following practice: Every morning or evening—which time best accords with the patient's habit of defæcation—he should, before that action, lie on his back, and *roll slowly over the belly a linen bag filled with small shot.*

The bag should by preference be rolled over the region of the colon and in the direction of the three portions of this intestine (the ascending, transverse and the descending colon). The duration of this manœuvre and the weight of the bag must vary according to the degree of the constipation and the patient's tolerance of the treatment.

This method, which operates, in short, like that of abdominal massage, and which



possesses over it the great advantage of being applicable by the patient himself, without the aid of another person, is said to give uniformly good results.—*Newark Bulletin*.

#### ROSIN WEED IN PHTHISIS.

From an instructive article by Dr. Robinson (*Med. Record*, July 15, 1893) we extract a few paragraphs. He says: All practitioners of medicine are, unfortunately, too familiar with the urgent difficulty of breathing which characterizes at times pulmonary phthisis. Occasionally this oppression accompanies the first stage of the disease; more frequently, of course, it is indicative of its terminal period. Whenever it occurs it is always most painful to the sufferer, and distressing to those who witness it.

I have tried to relieve it, in many cases, by the medicinal or mechanical means ordinarily recommended, with more or less success. I have never found, however, any drug preparation which has given me more satisfaction in its treatment than the tincture of *Silphium laciniatum* or "rosin weed." This tincture when taken in half-drachm doses, diluted with a little water, will often give very remarkable relief. And not only will it do this when the pulmonary structure is only partially affected with consolidation, but it will also show its power when the lungs contain many cavities and are infiltrated throughout with tubercular deposits. There are cases, unfortunately, in which *silphium* produces no apparent good results, and why it is I have not been able definitely to determine, further than to assume that the respiratory centres were incapable of further stimulation. Certainly, increase of bronchitis or occurrence of pneu-

monia did not always explain the fact. I have never known *Silphium laciniatum* to do any obvious harm to my patients, although, as I have stated, I have seen it remain without appreciable good effect.

Porcher writes that Dr. H. D. Garrison has reported this plant to be an excellent remedy for asthma. According to Dodd it has been used for the heaves, or asthma in horses. This disease is said not to exist in prairies where the plant grows. King states that the plant is affirmed to be emetic, and to be beneficial in dry, obstinate cough. It is said to be powerfully diuretic. R. O. Thompson also writes that the "plant, *Silphium laciniatum* (polar or rosin plant) possesses great medicinal qualities. Horses fed upon hay with it intermixed are never known to have the heaves. Cattle, sheep, mules, and horses are extremely fond of the heads of this plant while green, as well as mixed with hay. The pure white resinous gum which it contains performs radical cures in all bronchial cases." It will thus be remarked that, especially among animals, but also among men, this plant is recognized to have valuable medicinal qualities in asthma. I have given it on several occasions with manifest benefit to patients suffering with bronchial asthma. I have not thought it was of advantage in cases of cardiac dyspnoea. I wish to have my observations confirmed or discarded in phthisis, and for this reason would request those who read this communication to make use of the tincture of "rosin weed" and let me know their results. The tincture was made for me at St. Luke's Hospital according to the following formula:

R<sub>x</sub>. Fl. extr. silph. laciniatum (root) f3j.  
 Alcoholis . . . . . f3iv.  
 Aquæ . . . . . f3ij.  
 M. Filter. Sig. : 5 ss.—5j. as a dose.

#### NEW HYPNOTICS.

In a paper presented June 6th to the New York Neurological Society, Dr. Granger (*Journal of Nervous and Mental Diseases*) gave the following review of modern therapeutic progress in this department: In considering new sedative remedies, little need be said of the bromide group, which are valued mostly for their usefulness in the treatment of epilepsy. It is in the group of remedies best represented by chloral and called the alcohol and chloroform group that the great crop of new remedies is found. In their hypnotic effect the part of the brain representing the higher cerebral processes is first involved: first the cortex, lastly, the respiratory and cardiac centres. Those are the best hypnotics that act first and strongest upon the cortex, dull the sensibilities, both from within and without, lessen voluntary muscular activity and influence but little the vascular system and blood pressure. Among this group of hypnotics may be mentioned bromal-hydrate, which is said to be more dangerous than chloral and has but little value; chloralamide, which is less depressing than chloral, although serious collapse has followed its use. It produces quiet and refreshing sleep, with no unfavorable after-effects. It is not so certain in its action as chloral, nor does it act as promptly. The dose is from 30 to 45 grains; it is useful as an alternative to the other hypnotics. Chloral-ammonium, in doses of from 15 to 30 grains, is said to be non-depressive

and is a good hypnotic. Hypnol has the reputation of uniting the analgesic effects of antipyrine with the hypnotic effects of chloral. It is useful when sleeplessness and pain are combined, and the employment of opium is contraindicated. The dose of the drug is from 15 to 30 grains. Urethane belongs to the ethyl group; it is useful in milder cases of insomnia and for purposes of change; the dose is from 20 to 30 grains. Somnol is an alcoholic solution of chloral and urethane and is of little value. The dose is half a dram. Paraldehyde cannot be classed among the newer drugs; with chloralamide it is the only drug comparable with chloral in hypnotic power. They will win their way in the most difficult cases and are valuable in all cases of insomnia. Sulphate of duboisine is being used as a substitute for hyoscine. It is claimed that it gives more natural sleep and is less depressing. Sulphonal, tetronal and trional are so closely related as to be considered together. Almost everyone has a place for the first. It has marked hypnotic power. In ordinary doses it seems to be safe. Its long continuance is to be avoided, not so much that it quickly loses its power, for it does not, but because it is dangerous to health. Its action is often slow, for even if taken in the hottest water it sometimes seems to be precipitated in the stomach unless quickly absorbed. Its effects are frequently long-continued, and the second dose often acts better than the first. It is a pure hypnotic, but is less powerful than chloral. It is of little value when sleeplessness is associated with pain. Trional and tetronal are akin in many respects to sulphonal. They are all

true hypnotics and at present are attracting some attention.

#### CHLORATE OF POTASH IN STOMATITIS.

In a recent clinical lecture Dr. A. Jacobi (*Archives of Pædiatrics*, August) says:

The poisonous effect of the chlorate of potassium first described by me many years ago was attributed by me to nephritis, which is always found in such cases. But it was learned afterward that not only was there nephritis to account for death, but that there was a change of the hæmoglobin of the blood into met-hæmoglobin which in microscopic scales obstructs the capillary circulation, so that chlorate of potassium, as I pointed out several decades ago, is both a very beneficent medicine and a dangerous poison. Unfortunately it is still considered very mild and is used as a domestic remedy. I have myself seen a number of cases of death from its use, and since the publication of my first paper quite a number of fatal cases have been put on record.

If this child were to take half a drachm of the chlorate of potassium in twenty-four hours it would be well to dissolve it in five ounces of water and give a teaspoonful every half hour. Let him hold it in the mouth three or four minutes so as to secure the local effect and then swallow it. Taken in that way it will have a better effect both locally and constitutionally than if taken in larger doses at longer intervals. At all events, when you do give chlorate of potash a long time you should examine the urine before you begin its use, and every three or four days afterward. An adult could take a drachm and a half in the same

way, diluted in water, glycerin or other medicines, as tincture of chloride of iron, etc. The more frequently you give the drug the better, limiting the amount at a certain dose for the twenty-four hours. We are told that this child has also been taking permanganate of potassium, which is well enough, only it probably would do as well with the chlorate of potash alone.

#### SIGNS OF DEATH.

In the *Lancet*, June 10, Dr. Howard gives the following alleged signs of death and endorses all except No. 7, which is unreliable, since under certain circumstances the blood may remain fluid after death. The diaphanous test, the pink color between the fingers by transmitted light was found unreliable, since it could be gotten with equal distinctness in the corpse.

The signs alluded to are:

(1) Heart sounds and motion entirely absent, together with all pulse movement. (2) Respiratory sounds and movements entirely absent. (3) Temperature of the body taken from the mouth the same as that of the surrounding air in the room, 62° F. (4) A bright needle plunged into the body of the biceps muscle (Cloquet's needle test) and left there shows on withdrawal no sign of oxidation. (5) Intermittent shocks of electricity at different tensions passed by needles into various muscles and groups of muscle given no indication whatever of irritability. (6) The fillet-test applied to the veins of the arm (Richardson's test) causes no filling of veins on the distal side of the fillet. (7) The opening of a vein to ascertain whether the blood has undergone coagulation shows that the blood was



still fluid. (8) The subcutaneous injection of ammonia (Monte Verdi's test) causes the dirty brown stain indicative of dissolution. (9) On making careful movements of the joints of the extremities, of the lower jaw and of the occipito-frontalis rigor mortis is found in several parts.

#### WHEN TO EXCISE THE OVARY.

From an article by Dr. Polk in the *International Clinics* (quoted in the *Canadian Practitioner*, July, 1893) we select a few striking paragraphs:

Having made the abdominal incision, let the condition in which you find the ovary be the main factor in determining the question of procedure. If need be, the state of the ovary (as I have already suggested) may be determined by an exploratory incision or puncture.

Now, if the ovary contains pus, you should remove it, and with it the associated tube, my idea being that whenever an ovary is removed the tube should accompany it. If the tube contains pus, the ovary being free both from pus and from disseminative cystic degeneration, you are at liberty to amputate the tube, leaving the ovary; it being understood, however, that the patient is at liberty to demand the removal of all the appendages if she should so wish. The same general remark applies to cases of hydrosalpinx and hematosalpinx.

As you have already seen, cysts of the ovary do not, of necessity, call for entire removal of the organ. Where they may be enucleated, pursue that plan, following out the suggestions of operation as already outlined. An ovary which is enlarged from congestion, as in prolapse, can be cured by suspension better than by removal. Tubes with the fimbriated

extremity open, even though adherent and affected with parenchymatous inflammation and endosalpingitis, do not require removal, except when they open into pus-loculi, as in certain cases of pelvic abscess. The tube whose outer edge is closed may be opened and cleansed, its inner and outer coats united, and then returned to the abdominal cavity, provided it does not contain pus and possibly old blood, or its walls destroyed, as in hydrosalpinx. This is a procedure which you have witnessed here time and time again, and the results, in all cases which we have been able to reach, have been such as to justify the wisdom of the procedure.

Once for all, understand that adhesions do not demand the removal of the tubes and ovaries unless they be so dense that in breaking them the appendages are seriously injured. This presupposes that the appendages in themselves are not sufficiently diseased to demand removal.

#### INTERNAL MEDICATION IN MALIGNANT DISEASE.

In discussing the treatment of malignant disease by internal medication, Wright (*Annals of Surgery*, April, 1893) does not uphold this method to the exclusion of surgical interference, but rather advises its use in preparation for and in conjunction with the most thorough extirpation by the knife. For the purpose of destroying outlying foci of disease left by the knife, he tried various drugs internally, and in cases that he had operated upon, as well as in those in which operation was impossible, he began to give the bromide of arsenic in one-fortieth to one-tenth grain doses after meals, and the carbonate of lime before

meals in five to ten-grain doses in the tincture of calumba. In many cases coming under the head of sarcoma, there was quite a rapid tendency toward cure, and this was generally permanent. Large deposits, as a rule, would not yield, but excision of the enlargement was often followed by a sure cure. As to cases affecting bone, osteo-sarcoma, the treatment was not so favorable, but seemed of some value. He advises practitioners to give the bromide of arsenic to all patients as soon as they come under their care, and continue it for a long time after operation. In a considerable number of cases operated on for cancer in the past three, four and five years, to whom the bromide of arsenic was administered for a time, say six or twelve months, complete health has been restored and the scar tissue is now in every way just as normal as it would be if the wound had been in perfectly healthy tissue. In no case did the microscopic examination fail to confirm the diagnosis. The same results might possibly have been obtained by complete and thorough operation, and yet he believes there is value in the after-treatment, and that a case would be neglected without it. In inoperable cases he has seen good results, not the removal of the growth, but relief of pain and a retardation of the growth. In some cases of cancer of the intestines he has seen the bromide of arsenic bring relief and prolongation of life.—*American Journal of the Medical Sciences.*

#### MOVABLE KIDNEY.

In a recent Cavendish Lecture Dr. Morris (*Lancet*, June 17), speaks thus of movable kidney:

Whilst preserving the terms "misplaced" or "displaced" for the kidney which is permanently occupying an abnormal position, the word "movable" alone suffices to cover all cases in which the kidney from time to time shifts from its normal position but can be made to return by some movement of the bowels or of the body of the patient or by the hand of the surgeon. In justification of this simple classification let me state (1) that some of the most movable kidneys, those which float quite up to the front wall of the abdomen, cause no pain or other subjective symptom, and have no mesonephron; (2) that some of the cases in which the symptoms are most severe, most frequently recurring, and most likely to be mistaken for renal calculus, rarely and sometimes never can be detected by clinical examination as movable. It is only since surgical explorations of the kidney have been made that this form of movement, which I have elsewhere spoken of as "cinder shifting," has been shown to exist and to be the cause of very acute suffering. I have repeatedly in the operating theatre pointed out how a kidney can be moved around the tip of the fixed index-finger in every direction upon the plane of the loin, though it cannot be made to fall away from the back of the trunk even by rolling the person over on his face. Some of these cases have been explored in the belief that renal calculus was the cause of the symptoms; others, owing to the experience thus obtained, were diagnosed correctly, and nephrorrhaphy was performed with the most satisfactory results.

Another reason for the doubts which have been expressed as to movable kidney is the frequency of errors in diagnosis

whereby movable tumors of various kinds have been mistaken for movable kidneys. Mr. Lawson Tait told us some time ago that out of thirteen supposed movable kidneys which came under his notice seven turned out to be gall-bladders enlarged by dropsy or gall-stones. A similar mistake is recorded in the *Medical Record* of Feb. 18th, 1883, and three instances of the same kind have come under my own notice.

As to the severity of the symptoms excited by movable kidney and the relief afforded by nephrorrhaphy, no one who has witnessed the severest form of renal colic, the great general disturbance of health, and the nervous anxiety caused by the feeling of dragging or of something dropping from the loin to the groin—all removed by merely stitching the kidney to the parietes of the loin—can any longer doubt either the reality of the suffering or the benefit derived from the operation. I have known one case in which the sufferings were so great that chloroform had to be administered on many occasions for hours in succession before she was relieved by nephrorrhaphy; and another instance in which the patient experienced so much benefit from the operation that she had the other kidney, which was also movable, treated in the same way, and with an equally satisfactory result. The curative effects of the operation are most gratifying if the sutures are made to pass into the kidney substance; the loose fibro-cellular capsule is shortened and stitched also to the muscle and fascia of the loin. M. Tuffier recently stated at the Surgical Congress in Paris, when speaking on the distant results of renal surgery, that in every case of nephrorrhaphy the result was perfect when the operation was clearly indicated.

Though the patient's life is never directly threatened by the mobility, it is so indirectly through the changes wrought on the kidney by the interference with the patency of its ureter and by compression of its bloodvessels and nerves, so that when discussing the treatment for movable kidney it ought not to be forgotten that such an organ, like a kidney which is irritated by a calculus, runs the risk of being destroyed by hydro-nephrotic or suppurative changes. To obviate this risk as well as to remove a cause of suffering and bad health nephrorrhaphy should be performed before these destructive processes have been allowed time to develop. This ought to be pointed out when recommending an operation either for renal calculus or for movable kidney, and I feel sure when this danger is realised by the profession it will be to the great advantage of our patients. It is often stated that a well-adapted belt is all that is requisite for movable kidney. I have not found it so. Belts, pads and trusses of all kinds are very unsatisfactory for this condition. They do not often effect any good; they much more often aggravate the suffering when not applied by the surgeon or an intelligent nurse. The proper application of a kidney belt and pad, like the proper application of a truss for hernia, requires that the viscus should be in place. A patient can readily reduce his rupture, but it is not so with the movable kidney; it is neither so easily reduced nor so easily retained in position after reduction, and patients often find that they suffer more with the belt on than off, and this is owing to its being applied over the unreduced kidney.



## OPERATION FOR UNDESCENDED TESTIS.

In the *Lancet*, June 17, Dr. Bidwell writes: The treatment of undescended or partially descended testis does not appear to be very definitely laid down in any work on surgery. It is generally supposed that an undeveloped testicle in the inguinal canal is more prone to malignant disease than the normal organ, therefore when an operation has to be undertaken castration has been recommended. The reason for this severe measure is afforded by the bad results of any conservative method in the pre-antiseptic days; after such operations very troublesome and sometimes fatal suppuration occurred in the scrotum. When the testis can be forced out of the inguinal canal the patient may be provided with a truss with a horseshoe-shaped pad; after this treatment, which was recommended by Professor John Wood, the organ rarely descends further than the root of the penis and often retires after the truss is taken off. The method which I employ is as follows: The incision is the same as that for the radical cure of hernia and is not carried into the scrotum. When possible, the testis is squeezed out of the inguinal canal, but when this cannot be done the fibres of the external oblique have to be divided. The tunica vaginalis is then opened and divided just above the testis; if a hernia be present its upper end is dissected up and after being ligatured at the internal ring is cut off; when no hernia is present it is simply cut away. The fibres of the cremaster are cut across and the testicle is pulled away from the cord, whilst the structures between the vas and the epididymis are carefully divided with the

point of a knife. In this way the testicle becomes inverted, the vas entering at the top instead of at the bottom of the epididymis, and the vestigial remains (namely, the hydatids of Morgagni or the end of the Mullerian duct) at the top of the normal testis are now at its bottom. The result of the inversion is that the testicle hangs about one inch and a half lower and can be placed at the beginning of the scrotum. During the separation of the vas from the epididymis the spermatic artery, veins and nerves are divided and require ligature, but the artery of the vas, of course, is carefully saved. A finger is then pushed from the wound into the bottom of the scrotum and a mounted needle armed with a silk thread is passed through the skin on to the finger; the thread is thereupon withdrawn from the eye of the needle and the latter passed through the vestigial remains at the bottom of the inverted testis; the needle is then threaded again and withdrawn through the original puncture at the bottom of the scrotum. The inguinal canal having been closed by Macewen's method, the cut fibres of the external oblique are sutured and the skin wound united by a continuous suture. The two ends of the silk thread which has been passed through the end of the testis are then knotted together outside the scrotum and are attached by means of a piece of elastic drainage tube and a safety-pin to the crossbar of the wire cage. The accompanying engraving, from a drawing by Mr. Leonard Mark, shows the apparatus *in situ* and attached to it the traction thread issuing from the bottom of the scrotum. The dotted line represents the position of the incision. The cage

has previously been sterilized by boiling and strips of cyanide gauze are wound round the part which rests on the skin. It is fastened to the body by tapes passing round the waist and thighs, which fix it very firmly, the apparatus being not at all uncomfortable. The wound is dressed with cyanide gauze and the whole cage enveloped in an antiseptic dressing. The drainage-tube is tightened up next day, and again if necessary on the following day; the testicle will then probably be at the bottom of the scrotum. The cage should be kept on at least a week or ten days; when it is removed the thread is withdrawn from the scrotum.

Three successful cases are reported in detail by Dr. Bidwell; about six months later it was recorded that the testicles were still at the bottom of the scrotum and had not wasted, but rather increased in size.

#### CARBONATE OF GUAIACOL IN TUBERCULOSIS.

The value of guaiacol in the treatment of tuberculosis is now fully recognized. The drug, however, has many disadvantages, both as regards taste and smell, and more especially as to the disturbances of digestion which it is likely to cause. Carbonate of guaiacol has therefore been recommended as in a great measure free from these disadvantages. Carbonate of guaiacol is a fine crystalline powder, free from odor, tasteless and insoluble in water but slightly soluble in alcohol, ether, chloroform and benzol.

Therapeutically it possesses all the properties of guaiacol, but, as already said, none of its disadvantages. MM. Seifert and Koelescher, who have pre-

scribed the drug to sixty patients suffering from various forms of tubercle, speak highly in its favor and prefer it to creasote for the following reasons. Carbonate of guaiacol is not so irritating to the mucous membrane of the digestive tract; the gastric juice of healthy people has no effect upon it, and it is therefore not decomposed until it enters the intestine, when carbonic acid gas and guaiacol are set free. The stomachs of tuberculosis subjects, however, according to MM. Seifert and Koelescher, contain large numbers of saprophytic organisms and the drug is decomposed more rapidly, the free guaiacol preventing the further development of bacteria and so improving the digestive power of the stomach. The free guaiacol is absorbed rapidly, appearing in the urine within half an hour to an hour after its administration. As the carbonate is only slowly decomposed a uniform distribution of guaiacol throughout the intestinal juices can be obtained. Dogs and cats can take doses of 75 grammes without any dangerous symptoms. Patients can be given 6 grammes within twenty-four hours without discomfort, taken in divided doses. MM. Seifert and Koelescher likewise state that the blood of tuberculous patients contains pathological ingredients which cause hectic, night sweats, &c. Guaiacol unites with these bodies and forms inoffensive compounds, with immediate relief of the symptoms.—*Ex.*

#### ELECTRICITY ARISING FROM GAS- AND WATER-PIPES.

A writer in *Electricité* has made the interesting observation that there is a difference of potential between the water- and gas pipes in all houses and that if

one terminal of a telephone is joined to the water-pipe a crackling sound is heard in the telephone on lightly touching the gas-pipe, which of course indicates the passage of a current. By substituting a galvanometer for the telephone it is found that the negative pole is formed by the gas-pipe, the galvanometer deflection being permanent and constant in amount during several months, though there is a slight diurnal variation. These experiments have led to the suggestion that the pipes must be fairly well insulated from one another and might really act as conductors for telephonic communication. As a matter of fact it is stated that conversation was successfully carried on without any other conductor between two houses at a distance of 100 metres apart, the microphone used in the experiment being joined to three bichromate cells. The small though distinct currents that are set up when the gas- and water-pipes are connected are attributed to a slow chemical change in the pipes, which may thus represent the plates of a battery. This hypothesis leads one to think of the probable nature of these changes and to wonder whether any effect is produced in the water contained in the water pipes, or whether perchance minute traces of metal as a result of the change would find their way in solution into the water. If the latter event took place another and hitherto unsuspected source of lead poisoning might possibly be traced.—*Ex.*

### Medical Items.

Dr. I. R. Trimble is spending his vacation at Longwood, Md.

Dr. W. H. Jennings, of Peaksville,

Va., paralyzed a month ago, is not expected to live.

Massage of the abdomen and general massage is recommended by Eccles in megirim, which he finds always attended with faulty digestion and mal-assimilation.—*Ex.*

Dr. J. H. Scarff has entered suit against John Turnbull, Jr., & Co., for \$5,000 damages, for alleged loss caused by issuing attachment.

Dr. Wm. Grebe, one of the best known German physicians, died last Sunday at Richmond. He had practised 40 years.

A foreign physician suggests the application of leeches in a case of suspected but uncertain death, on the ground that leeches cannot draw blood from a dead body.

Physicians out of town:—Dr. T. Chew Worthington, Hotel Wellington, Atlantic City. Dr. Harry Lee Smith, Warren, Va. Dr. H. G. Ulrich, Raquette Lake, N. Y. Dr. E. E. Mackenzie, Denver, Col. Dr. W. J. Wroth, Boston, Mass.

Maryland physicians at the Fair: Drs. F. R. Nordham, Jos. F. Martenet, O. E. Janney, Jas. A. Stewart, J. McP. Scott, D. S. Williams, A. C. Pole, G. W. Lehman, L. E. Neale, W. Clement Claude, J. W. Skilling, Cora B. Brewster; T. A. Wright, F. G. Horner, Julius E. Grammer and E. E. Mackenzie.

Delegates to the Pan-American Medical Congress, to be held in Washington, next week, will visit our city Sept. 8th. At 2.30 P. M. they will be met in carriages by physicians selected as a com-



mittee to entertain the visitors. Hopkins Hospital, University of Maryland, College of Physicians and Surgeons, Baltimore Medical College, Women's Medical College, Maryland General Hospital and other points of interest will be shown. Later, a trip down the river and banquet on board a steamer.

"What did de doctah say ailed yer mostly, Bill?" "He showed dat I had a conflagration of diseases. Fust, de salvation glans don't insist my indigestion; dat makes a torpedo liver; cose I'm liable to go off any minute."—*Ex.*

We are informed by the daily press of the decease in Brunswick, Georgia, of Dr. John W. Branham, brother of the well-known professor in the Baltimore College of Physicians and Surgeons. Dr. Branham was but twenty-five years old. After serving as Resident Physician in the hospital attached to the above-named college, he entered the Marine Hospital Service. Attaining unusual skill in sanitary matters, he was sent to the station at Brunswick, where he contracted yellow fever, and died after a week of illness. The sadness of the premature death of such a talented physician is intensified by the fact that his wife was detained by illness in Baltimore from ministering to her husband in this unequal struggle against the fatal fever. To her and to his brother we would extend heartfelt sympathy in this bereavement.

We are informed that there is to be a change in the place for the examination of candidates for admission to the medical corps of the army. Heretofore all examinations have been held in New York City on account of it being the

place from which most candidates have come. By a decision of the Surgeon-General, candidates hereafter will be examined in Washington at the new school of instruction recently organized for an advance course for surgeons after they enter the service. The first examination will be held on September 11, to fill six vacancies now existing and three more soon to be created by retirements. The board which will pass upon the qualifications of candidates for admission is composed of Colonel Charles Alden, Lieutenant-Colonel Forward, Major Charles Smart and Captains Walter Reed and J. C. Merrell. Those who pass the examination to fill the vacancies will constitute the first class to take the new course of instruction. The young doctors will also be given instruction in hospital service and drills in the first aid to the wounded at the Washington barracks, where a company will be assigned for the duty.

It is not poverty of diet so much as monotony of diet that exercises an unhealthy influence on the poor. As a matter of fact they eat "stronger" food than the rich, more bread, meat and simple vegetables, but their cooking is rude, and they eat the same things the whole year through. People who are well to do, or who are better cooks, get more variety with fewer things, and always have something to tempt the appetite. Soup can be made to resemble greasy dishwater, or it can be made a really savory and nutritious thing, and there are a hundred different ways of serving potatoes. Free cooking schools would be a first-class thing in the tenement districts of large cities.—*Ex.*

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## Original Articles.

### SUSPECTED PREGNANCY AFTER OOPHORECTOMY.

BY WILLIAM PAWSON CHUNN, M. D.,  
OF BALTIMORE.

It is not frequently the case, Mr. President, that a woman, having been castrated, is accused of pregnancy. Such a charge, however, was brought against an unfortunate, who in consequence came under my care some three weeks ago. A certain gentlemen, being interested in the matter, called at my office and recited the following details. For a number of years he had been unduly intimate with a young lady of this city, who a year ago had been castrated by a well-known gynæcologist of Baltimore.

She recovered from the operation, and for about nine months still sustained her monthly flow. About this period after the operation the intimacy formerly existing between the the two was renewed, which in turn was followed by entire cessation of the monthly flow. Morning sickness appeared, adding to the discomfort of both parties, which symptoms induced a guilty conscience to believe pregnancy certain.

The foundation for this belief lay in the fact that after the operation the surgeon was asked whether all the ovarian tissue had been removed, to which question he had replied by saying he thought so, but was not certain. It seems also that the patient was not aware of the fact that after excision of the tubes and ovaries menstruation ceases in about ninety-five per cent. of

the cases so treated. I then proceeded to find out the reasons for operation and discovered the following particulars. It seems the gentleman before mentioned, according to his statement, had never had relations with any other woman except the one in question. He also at first denied having had gonorrhœa, but promptly admitted that he had had, some two years before, a yellowish discharge from the penis, accompanied by scalding during micturition. How he had contracted this disorder he knew not, and whether he had infected the woman, or whether she had infected him, was more than he would say, or I either. It is quite possible, notwithstanding general opinion to the contrary, that he became infected otherwise than through the usual source. The twain having appeared at my office by appointment, I questioned the woman and found that for a long time previous to operation she had complained of pelvic pain, cramps, and a yellowish vaginal discharge, with pain and scalding during micturition. The symptoms had been relieved, and she now desired to know whether she was pregnant or not. I found the uterus in normal position, normal in size, and the cervix not soft, but of a normal consistency. I therefore had no hesitation in excluding pregnancy, when reinforced by the other details of the history; and as I have heard nothing since I presume the diagnosis was correct.

It seems strange that a man should infect a woman with gonorrhœa and still be ignorant of the manner in which he himself contracted the disease. We know that such diseases as diphtheria, typhoid fever, tuberculosis, &c., are contracted

in many ways and by means which are at times unexplainable, but if a man presents himself and says he has got gonorrhœa but don't know how he got it, he is greeted with a smile of incredulity. I do not doubt that in some cases an imperfectly constructed closet is the cause of the mischief. In such cases the bowl or basin of the closet is quite shallow and as its sides approach the seat at an acute angle, its surface is only 2 or 2½ inches below the level of the seat. A preceding party, if infected, using such a closet, would be apt to leave a legacy to his successor. Indeed, to show that this is quite possible I have only to mention the case of a gentleman who upon rising after defecation found the extremity of his penis covered with blood. He, however, sustained no bad consequences; and upon investigation he discovered that a member of the household was menstruating. Now, it seems to me that such a closet as that might be the means of disseminating wide-spread disease.

Another symptom connected with this case was the morning sickness and nausea. While we look upon this symptom as natural and to be expected in pregnancy, we are somewhat surprised to see it suddenly and typically developed outside of that condition. I have quite frequently seen it appear, however, almost immediately after sexual relations in the unmarried, and as subsequent observation determined, without the existence of pregnancy. It would be interesting as well as useful to know the number of women who recover from gonorrhœal endometritis and salpingitis without resorting to a radical operation, but I am familiar with no statistics on this subject. I believe, however, the ratio of re-



coveries is much smaller in women than in men.

The reason for this statement it seems to me to be quite evident. In the male the disease is recognized at once; the diseased organs are easy of access and the ascent of the poison is continually opposed by the descending stream of urine. In gonorrhœal ovaritis, salpingitis and endometritis these favorable conditions do not exist and consequently in the early stages the diagnosis is doubtful and the treatment inefficient. We have, however, a valuable aid in the microscope, by which we can tell in the beginning a gonorrhœal urethritis, vaginitis or endometritis, but I regret to say not always a salpingitis. This, however, is the most important condition of all. Without physical signs in these initial stages we can only hope for the best and be content to watch and wait.

1023 Madison Avenue.

### REMARKS ON FIFTY MASTOID OPERATIONS DONE IN THE PAST FOUR YEARS.\*

BY B. ALEXANDER RANDALL, M. D.,

Professor of Diseases of the Ear. Philadelphia Polyclinic; Clinical Professor of Otology in the University of Pennsylvania; Etc.

The opening of the mastoid portion of the temporal bone for the evacuation of pus, after the unmerited eclipse into which it had been cast for nearly a century, has gained increasing use and advocacy during the last few decades. Begun as a desperate resort, and often withheld too long in cases demanding it, it has been practised with increasing boldness by general and special surgeons

with the result that timely and careful employment has greatly improved the record of its results; yet it has again been employed under doubtful indications, in a way that has raised anew questions as to its propriety. The great advance in intra-cranial surgery has shown that conditions once regarded as hopeless can be successfully combated by modern methods. The timid plan of cutting down upon the mastoid and resting satisfied with that, is growing less frequent, since the conservatives are forced to admit that they have then to wait for months or years for nature to loosen or throw off dead tissue, of which most, if not all, might be removed with safety in a few minutes; and wider clinical and anatomical study is showing the way more clearly to radical but truly conservative measures. Yet the aurist can never forget that the organ of one of the most important senses is committed to his care, nor be content if he has avoided the dangers to life at needless cost to the hearing. The relative safety of timely operation has been proven by the fact that death is growing steadily less frequent in operated cases, and falls far below the proportion of fatalities where operation is indicated, yet refused. At the same time we are improving the definition of the larger group of cases where vigorous antiphlogistic treatment, by hot douching, dry heat, and rest in bed, will safely avoid the dangers of mastoid inflammation and obviate the resort to operative intervention. The wider spread of rational treatment of tympanic suppurations will doubtless do as much to lessen the frequency of serious intra-cranial extensions as the better and more hopeful

\*Read before the Philadelphia County Medical Society.

diagnosis of their occurrence and accessibility during life will bring them into notice as demanding intervention and yielding to surgical skill.

The notable results obtained of late years by general surgeons has called more widespread attention to this field and awakened more general interest; but it should not be forgotten that it has been quite frequently the aurist who has diagnosticated the case, indicated the operation, and only sometimes called in the general surgeon to perform it. And while the aurist has rarely reported his results in these fields in general meetings and journals, it has not been because he has not obtained the same brilliant success, though oftener without than with perilous and somewhat questionable operation. It should be better known than it is that the suggestion to open and evacuate the thrombosed lateral sinus was put forth by Zaufal ten years before it occurred to Victor Horsley; and that it has been rarely done by aurists because by mere mastoid trephining they have obtained recovery in too many pyæmic cases, where the long-known purulent thrombosis in the mastoid emissary vein showed thrombosis of the lateral sinus. It has been suggested that the aurist ought to call in the general surgeon to do his mastoid operations; and surgeons in conclave, as in Berlin a few years ago, have found much fault with the lack of radicalism which we often show. But Küster, who was the most hostile critic, showed in the discussion that he had small and none too brilliant experience of mastoid trephining and had no adequate acquaintance with the methods or results of the aurists whom he criticised.

The method of chiselling away the back wall of the auditory canal, which he advocated, has long been employed by aurists, like myself, in the appropriate cases, but will probably not often be practised as the routine procedure by anyone having fair respect for the organ of hearing and a knowledge of the perfect results generally obtainable at less risk and cost. That v. Bergmann and others have had large and valuable experience in this line is undoubted; yet what general surgeon has done some three hundred of these operations, like J. Orne Green, of Boston, Schwartz, of Halle, and several other otologists?

Having done less than a hundred operations myself, I can take but a low place in the list of aural operators; yet few, if any, of the general surgeons of this or other cities can cite a wider or a better series of cases. Men are known sometimes by their failures, and perhaps some of you can tell of more unsucccess on my part than I am myself aware of; yet I, too, could point to many histories of cases that came to me from other men, or, leaving me, have died under the hands of others. And it is because it is very hard for the operator to gain such knowledge as to the ultimate results of his cases that I here present my experience for criticism and emendation. Doubtless the four years of epidemic influenza have greatly influenced the matter of mastoid inflammation and enforced more frequent resort to operative intervention, for the notices of such cases have redoubled during this period, and my operations, previously infrequent, rose to seven in 1889, ten in 1890, fifteen in 1891, and twenty in 1892. The increase of my ear patients from some

1200 at the earlier, to 1500 at the latter period, has combined with other influences to enlarge my experience in this direction; but other men have the same increase to report. Roosa, who has always advocated operation, had but thirty-four cases to report from his twenty years' work up to 1890, and has since then opened the mastoid more than a hundred times; and Schwartze, who took from 1864 to 1883 to obtain his first hundred operations, has been doing them in treble proportion since. Yet the finding of past years, that about 3 per cent. of my ear cases presented evidences of mastoid inflammation and about one-fourth of these demanded operation (50 cases among 5000), has not been verified this year; and whereas, the first half of 1892 gave me fourteen operations, but few mastoid cases and a single operation have been met this year. Most of these operations I have myself performed, but a few have been done by others—as some of the University cases by Dr. Brown, the Instructor in Otology, and the one of this year was kindly done by Dr. William S. Taylor during the incapacitation of my right hand.

As a result of the study of some two hundred cases where the suggestions of mastoid trouble, as furnished by pain, redness, œdema, apparent fluctuation, and deep-seated tenderness to pressure, have been decidedly disquieting, I believe that quite three-fourths of such cases can be brought safely through without resort to operation; and that unless the symptoms are urgent, or the fluctuation unmistakable, the surgeon can give a fair trial to vigorous use of heat by douche and hot-water bottles, with rest in bed and good hygiene. But a number of my

patients were brought to me after all hope of resolution was gone; and when pus is present in or on the mastoid, I can imagine little cause for delay in evacuating it. The fatal results of the disease may not always be avoided; slow, tedious healing may be the best that can safely be secured, and facial palsy or impairment of hearing may prove irremediable, or may even occur after operation. Prognosis must be cautious, and one should never promise his patient anything more than that he will give him his best judgment and skill; yet, none the less, in careful hands the opening of the mastoid will continue to give, as it has done in thousands of cases in the past, the fullest justification for its performance. The fifty cases which I here report include but two of known fatal issue, although others ultimately died of tubercular meningitis or related troubles, as my specimens will show. Only one case (which has been reported in full elsewhere) gave room for ascribing the death to the operation, and it is the only case in which it might be said that no pus was found in the carious antrum. Generally a bone sinus was already present, sometimes already communicating with the exterior, and the operation was the rather trivial one of curetting or otherwise removing the carious portion of the bone. While fully believing in the desirability of the removal of every particle of pathological tissue, whether soft or bony, with closure of the wound for primary healing, I doubt if this can often be safely attained. Due regard for the important structures in and around the field of operation demands that with full knowledge of the anatomy we shall be radical in directions where it is safe even to overdo the abso-



lute requirements, but conservative to the verge of timidity as to opening the facial or semi-circular canal, the middle cerebral fossa, or the lateral sinus. Recovery has often taken place uncomplicated by such an occurrence; but its needless performance should be regarded as a blunder which might prove disastrous.

The technique of operating should vary with the nature and needs of the case. Usually a liberal incision close behind the auricle, free exposure of the bone and penetration by the gouge close behind the auditory canal *below* the level of its upper margin and the *spina supra meatum* is safest and surest to reach the antrum. The claim of Koerner, that the cranial measurements give any assurance of safety or danger, are wholly unsubstantiated by my far-wider study. The advice to operate in any one way, as urged by Küster, with more than the minimum requisite of violence to the integrity of the parts, I unhesitatingly condemn as irrational. The intricate mastoid cavities cannot by any fair thoroughness be surely made and kept aseptic, and extensive areas of freshly-opened bone afford perilous opportunities for septic absorption.

Cases are met where the lateral sinus, covered by the merest film of bone, fully occupies the ordinary field of operation, and it may even be visible through the intact bone; therefore, close scrutiny of the uncovered mastoid is a prerequisite to any penetration. The trephine or drill is being less used by all men who operate often, since study and experience show that in the dangerous cases their use is less safe than the gouge. It remains to be seen how far the mallet can be safely employed, in spite of the

advocacy of Schwartze and his disciples; for my part, I expect to use it very rarely. The hand-gouge is safer, though slower, and can be carried through the hardest bone. Within the mastoid the spoon and burr are the safest instruments for carrying the opening inward, forward, and slightly upward to the antrum. The middle cerebral fossa is rarely as low as the upper wall of the meatus, and never below it, at the point of operation. The facial and semicircular canals are never less than 15 mm. from the spina, and in a large convex mastoid even greater penetration may be safe; but the antrum ought always to be encountered without going deeper. Drainage and access to the antrum is the principal point in the great majority of cases, with extension of the operation in any other direction according to the needs. Irrigation is a questionable measure, both in operation and after-treatment, and is better avoided. Drain-tubes, gauze packings, and open treatment of the wound are unfortunate necessities in most cases, but should be avoided, if safely possible; the free incision being narrowed or closed by sutures. Healing is possible by first intention in a few days; but several weeks of after-treatment are usually requisite; and if thoroughness has not been practised because of real or groundless fear of doing too much, or the patient's recuperation is poor, months may pass before full healing can be gained. Recurrence may take place under provocation, just as the other ear may be similarly involved, but this will be rare after a proper operation, and, like the occasional deaths, will be in spite of the operation and its real benefits.

Whether operated on or not, mastoid

empyema will generally be a very dangerous condition, calling for the fullest skill of the medical man to prevent it, if only incipient, to diagnosticate it, if present, and to treat it and its consequences with fearless conservatism.

### Society Reports.

#### CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD MAY 5TH, 1893.

The 281st regular meeting of the Clinical Society was called to order by the President, Dr. Wm. E. Moseley.

*Dr. W. J. Jones* read a paper on NASAL REFLEXES. The history of the subject was briefly referred to. Dr. Jno. A. Mackenzie's observations were quoted as rendering it probable that the reflex area is limited to the mucous membrane covering the middle and inferior turbinated bodies and the posterior half of the septum. These reflexes are more constant when the mucous membrane is congested or inflamed, but still, in the author's experience, they do exist even when there is no evidence of nasal disease. This same fact has been observed by Bosworth, Mackenzie and others. Dr. Jones narrated two interesting cases from his own practice.

CASE. I. A girl of sixteen. Had had a short dry cough for several months, which had resisted all treatment and had compelled the girl's absence from school. Examination of the chest organs proved entirely negative. Mucous membrane of the larynx and pharynx somewhat congested. In the nasal cavity the mucous membrane of the middle and inferior tubinated bones and of the

septum considerably swollen and very red. Exquisitely sensitive to touch. Anodyne remedies were given and local applications of Dobell's solution, menthol, aristol, etc., were made. The introduction of the applicator was followed by violent paroxysms of coughing, but if the applicator was preceded by an application of four per cent. cocaine, no coughing followed. This fact led to the diagnosis of reflex cough due to an extremely sensitive condition of the nasal mucous membrane. The galvano-cautery was used on the middle and inferior turbinated bones and septum of both sides. The tissues rapidly healed and the coughing lessened each day and at the end of about two weeks was entirely absent. She is better now, a year afterward, than ever before in her life.

CASE II. Miss B., aged 35 years, suffering greatly from asthma with the slightest change in the weather. Had spent 4 years in Colorado without any alleviation of her suffering. Nothing abnormal found in the chest. Pharynx and larynx somewhat congested. Several large mucous polypi found attached to the middle turbinated bones of each nostril. The growths were removed by a Jarvis snare, October, 1892, and bases touched with galvano-cautery. The patient's breathing became better immediately and she enjoyed a good night's rest, a thing she had not done for many months before. She remained under observation but a short time afterward but during that time she was perfectly free from her old trouble.

*Dr. G. J. Preston* then exhibited a patient with complete motor and partial sensory aphasia. He also showed to the Society the brain of a person who had

been affected in almost exactly the same way.

*Dr. Frank Martin* read a paper on INTERNAL URETHROTOMY AND ITS CONSEQUENCES.

Although internal urethrotomy is justly deemed one of our best methods of treating stricture, yet it is not always so free from danger as some of the enthusiasts on the subject would lead us to suppose. The teachings of *Dr. Otis* on his work on stricture and the numerous articles he has written have been rather misleading. From them one would be inclined to believe in internal urethrotomy as a sure and radical cure of stricture free from all danger to life, permanent in its results and followed by no complication worthy of mention. We must accept with caution the claims of this operation. *Dr. Otis* reports more than a thousand operations in his own practice with no death, no abscess, no escape of pus into the tissues nor an attack of pyæmia. In striking contrast to this report, *Dr. Martin* quoted *Dr. Reginald Harrison, F. R. C. S.*, who reports several cases of death following the operation. *Dr. Martin* while at the University of Maryland had under his care some eighty-odd cases of internal urethrotomy and fifty-odd perineal sections, performed by the different surgeons as they came on duty. Of the internal sections, one died. The patient was a man aged 51, with a stricture of 25 years' standing, almost closing the lumen of the canal. He had several abscesses around the base of the penis not communicating with the urethra as far as could be ascertained. The abscesses were opened and allowed to heal. Later the stricture was dilated by a No. 8 Eng-

lish sound. Ether was given and an *Otis* urethrotome passed, the entire urethra dilated up to No. 18 English, and cut. Then a No. 18 sound was passed. Operation at 11 A.M.; patient reacted readily from ether. At 1 P. M. had a severe chill; soon became comatose. At 4 P. M. temperature 105° in axilla and pulse hardly perceptible. Died at 11.20 P. M. No urine passed. After death one half pint bloody urine drawn from bladder.

Another fatal case occurred in *Dr. Martin's* private practice. The man had an old stricture and retention of urine, but otherwise was in apparently good health. Stricture was about 3½ inches from the meatus. The retention was relieved but efforts to dilate the stricture were unavailing. Urine normal. Under ether the *Otis* dilating urethrotome was used and he was cut up to No. 18 English. Reacted nicely from anæsthetic. Had a chill 22 hours after the operation and died in a convulsion 3½ hours later.

A third fatal case occurred in the practice of a young Baltimore surgeon. A man of 38 had a stricture of seven years' duration. The stricture was gradually dilated up to 22 French over a space of two weeks, when it was divided with an *Otis* urethrotome, the instrument being dilated up to a 29 French before cutting. The patient had a chill in a very few minutes after division of the stricture, followed in about two hours with symptoms called by the patient's friends "spasms." He died in convulsion 7½ hours after the operation. The urine before operation showed a slight cloud of albumin. The urine obtained from the bladder after the operation was loaded with albumin and tube casts.

Uræmic convulsions and septicæmia



are the most important of the unfortunate consequences of internal urethrotomy. Hæmorrhage, defective expulsive power, etc., are of minor importance.

WM. T. WATSON, M. D., Sec'y.  
1519 Broadway.

#### INTERNATIONAL CONGRESS OF PUBLIC HEALTH.

We have received the Preliminary Announcement of the Twenty-first Annual Meeting, which in connection with the World's Congress Auxiliary of the World's Columbian Exposition will constitute an International Congress of Public Health, to be held at Chicago, Illinois, Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday, October 9, 10, 11, 12, 13, 14, 1893. An elaborate program is promised.

The American Public Health Association was organized in 1872, by a few public-spirited men who foresaw the need of bringing together in one body the ablest sanitarians in the country, for the purpose of inaugurating measures for the restriction and prevention of contagious and infectious diseases, and for the diffusion of sanitary knowledge among the people. The growth of the Association and the work it has accomplished more than justify its existence. Its membership has been augmented from year to year, until it now constitutes the largest and strongest sanitary body in the world, and embraces in territorial extent the United States, the Dominion of Canada and the Republic of Mexico. Under the impetus given by its work, State and local boards of health and sanitary associations have been organized, sanitary publications increased, and hygienic knowledge widely and extensively

diffused. The Association has already published eighteen large and valuable volumes, increasing at the rate of one a year, and containing the papers, reports, and discussions presented at the annual meetings. These volumes constitute in themselves a library upon sanitation; they are elegantly printed and bound, and are alone worth more to any person interested in hygiene than the cost of membership. Each member is entitled to the annual volume, delivered free of expense. In addition thereto, the Association has published a standard work upon "Disinfection and Disinfectants," besides the Lomb Prize Essays, now so widely known to the American public.

Among its members may be found physicians, lawyers, merchants, plumbers, civic and sanitary engineers, health officers—in fact, every profession and many of the industries are represented in its list of members. The only qualifications required for membership are a good moral character, an interest in hygiene, and the endorsement of two members of the Association. The cost of membership is five dollars a year. For blank applications for membership, or particulars relating to the Association, address the secretary, Irving A. Watson, Concord, N. H.

One of the most embarrassing experiences of the young physician is due to the habit of the ladies, not his patients, in families where he visits socially in the evening, asking him in an off-hand way "what is good for neuralgia," or "what do you give for the headache?" A box of one-tenth grain calomel tablets carried in the vest pocket will meet these emergencies and gain great reputation for the doctor.

## MARYLAND MEDICAL JOURNAL,

A Weekly Journal of Medicine and Surgery.

A. K. BOND, M. D., Editor.

*Subscription \$3.00 per annum, payable in advance.**Contributions from practitioners in good standing invited, and advertisements from reliable houses solicited.**Contributors to this JOURNAL will please take notice: All articles for publication must be written in INK, and on one side of the paper; otherwise the Editor will not be responsible for typographical ERRORS.**All communications relating to the editorial department of the JOURNAL and books for review, should be addressed to the editor.*Address all business communications to the  
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BALTIMORE, SEPTEMBER 2, 1893.

**Editorial.**ABSORPTION-POWER OF  
URINARY BLADDER IN HEALTH.

We have received from our friend, Dr. B. London, the veteran physician of Carlsbad, a preliminary communication of work done by him during the winter in the Laboratory of Experimental Physiology, at Leipzig, upon the method and degree to which substances are absorbed during health by the walls of the urinary bladder.

Such experiments are of interest because of the diametrically opposite statements of former observers; some of whom, as Orfila, the two Segalas, Bernard, Kaupp, Demarquay, Longet, Hicks, Paul Bert, Brown-Sequard, Gubler and Treskin, state that absorption does take place; while others, as Civiale, Küss, Sir Henry Thompson, Alling, Susini, Paul Cazeneuve and Charles Livon, have gotten negative results only.

In the experiments now reported, Dr.

London injected, into his own bladder, first a warm  $\frac{1}{2}$  per cent. solution of potassium iodide. The analysis of the saliva gave no trace of iodide.

In the second experiment, he injected a  $\frac{1}{2}$  per cent. solution of chloride of lithium. Spectral analysis of the saliva yielded the characteristic red line of lithium.

In a third experiment, after injection of potassium iodide, a feeble reddish-blue coloring of iodide was obtained from the residue of the saliva by treatment with sodium carbonate, potassium nitrate and chloroform.

Most careful microscopical examinations of the bladder epithelium in the laboratory have shown that, however greatly the bladder may be distended short of rupture there is neither displacement nor break in continuity of the epithelial stratum; but that individual cells, being very elastic, decidedly change their shape; proportionally to the total change of all the epithelial structures.

## THE THOMAS WILSON SANITARIUM.

The Thirteenth Annual Report of this excellent charity lies before us. From this and from other sources we learn that a very important advance has been made in the working-methods of the institution. The custom, formerly observed, of taking children to the sanitarium in large numbers for one day only, has been discontinued. During the present season only those mothers and children have received tickets to the Sanitarium (at Mt. Wilson, on the Western Maryland Railroad) who were expected

to stay there for some days or weeks until recovery of the child should take place. This plan has been found to give excellent results, far superior to the quite doubtful benefits of the daily excursions.

Dr. Booker is still Physician-in-Charge, Dr. Brevitt being Assistant, as before.

The buildings for reception of the sick have been greatly extended since the sanitarium was first noticed in these columns.

During the present season, tickets of admission have been issued, not by the city practitioners as heretofore, but by five trained nurses who have reception offices, each in a different section of the city, open from 8 A. M. to 11.30 A. M.

These offices are at 1520 E. Eager St.; 254 S. Broadway; 820 Light St.; 117 Scott St.; and 1337 Fremont St.

In case the child is too ill to be brought to the office, the nurse visits it at its home and arranges for its transportation to the sanitarium.

The advantage of this substitution of district nurses for local physicians will be seen at a glance.

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### Reviews, Books and Pamphlets.

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*Quarterly Atlas of Dermatology*; An illustrated quarterly journal of skin and venereal diseases. Edited by A. H. OHMANN-DUMESNIL, M. D. Subscription price \$1 per annum. Published by the Quarterly Atlas Co., 1 North Broadway, St. Louis, Mo.

We have received with pleasure the first numbers of this new magazine. It contains original articles on various

themes embraced within the above specialties. Most if not all of these articles seem to be from the pen of the editor, whose abundant labors have made his name well-known throughout the country.

The special point of attraction is in the large number of full-page illustrations from photographs, taken, we suppose, from the editor's hospital and private practice.

To what extent clear ideas of the peculiarities of dermatological lesions can be obtained from such uncolored prints, is a matter open to dispute. As a testimonial to the energy of the St. Louis editor, they are certainly a success.

*The Johns Hopkins Hospital Reports*; Vol. III, Nos. 4, 5, 6. Report on Pathology III. Baltimore Md.: The Johns Hopkins Press, 1893.

In the present issue of this excellent publication, embodying high-grade work done in the medical side of the Johns Hopkins foundation, we find five articles.

I. On Multiple Lymph Sarcomata, by Dr. Simon Flexner. The author analyses carefully certain cases which have come under his observation, with special reference to metastasis, and comes to the conclusion that in its metastasis lymph-sarcoma manifests the characteristics not of a true tumor, but rather of an infectious disease due to a specific micro-organism.

II. A study of the Cerebellar Cortex of the Dog, by Dr. Henry J. Berkley. This article is illustrated by excellent original plates.

III. A case of Chronic Nephritis in the Cow, by Dr. W. T. Councilman. The paper is interesting, both on account of infrequency of the disease in animals,



and because in the present instance it seemed to be of bacillar origin.

IV. On Bacteria in their Relation to Vegetable Tissue. By H. L. Russell, Ph.D. The investigator here records a very interesting incursion into a field of research hitherto almost untrodden. What becomes of bacterial micro-organisms when they are injected into plant tissues; what resistance is offered to their lodgment by the peripheral and the inward cells of the plant; how this resistance is modified by injury or disease of the plant; these are the themes subjected to discussion. Appended to the article is a list of the Bacterial Plant Diseases with a brief account of their Principal Characteristics.

V. An Analysis of 105 cases of Heart Hypertrophy from the Autopsy Records of the Johns Hopkins Hospital, by Dr. Wm. T. Howard, Jr. The author draws practical conclusions in regard to the unexpected frequency of arterio-sclerosis in Maryland, where it is "the most frequent of the cardio-vascular diseases after 30 years of age."

*United States Naval Laboratory and Department of Instruction, New York.* Published in Washington; Navy Branch G. P.O., 1893.

This little pamphlet contains a description of the course of instruction given in New York at the Naval Hospital.

All Assistant Surgeons as soon as commissioned are ordered to this institution for a course of instruction, lasting at least three months, in chemistry, hygiene, microscopic work, surgery, medicine, ship-construction and ventilation, life saving methods, etc.

*The Buena Vista Spring Hotel; P. O., Buena Vista Spring Station, Maryland.*

Announcement for 1893. A favorite health-resort well-known to Baltimoreans.

*Fifty third Annual Announcement of Lectures and Catalogue of the Medical Department of the University of New York. Session 1893-94.*

*The Gross Medical College Bulletin (Monthly).* Denver, Colorado, May, 1893.

*Cremation; And its Importance in Cholera.* From the *Sanitarian*, April, 1893. Abstract of Discussion at stated meeting of Northwestern Medical and Surgical Society of New York, January 18, 1893. By Dr. Robert Newman.

*The Present Status of Electrolysis in the Treatment of Urethral Strictures; with Statistics of 100 Cases (3rd Series);* by ROBERT NEWMAN, M. D., of New York.

A paper read at the Second Annual Meeting of the American Electro-Therapeutic Association, October, 1893. Reprint from *Journal American Medical Association*, April 15, 1893.

*College of Physicians and Surgeons, Baltimore.* Annual Announcement and Catalogue for 1893-94.

The high reputation and costly equipment of this school are a credit to our city as well as to those physicians and surgeons who have made it a success.

The energetic Dean of the Faculty, Dr. Thomas Opie, will receive applications for matriculation and correspondence at his office in the College Building, corner of Saratoga and Calvert Sts. The course is three years graded. Preliminary lectures will begin September 15th.

The Faculty have just built a separate

hospital (capacity 100 beds) for colored persons; the first hospital exclusively for that race in Maryland.

*A Chapter on Cholera for Lay Readers: History, Symptoms, Prevention, and Treatment of the Disease;* by WALTER VOUGHT, PH. B., M. D., Medical Director and Physician-in-Charge of the Fire Island Quarantine Station, Port of New York; Fellow of the New York Academy of Medicine, etc. Illustrated with Colored Plates and Wood-Engravings. In one small 12 mo. volume, 110 pages. Price, 75 cents net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

In this small volume we find a very interesting and instructive account of cholera, well calculated to inform the mind of the public concerning its prevention and the principles on which its treatment is to be conducted.

The book begins with a short sketch of the earliest records of the existence of cholera and proceeds to enumerate the pandemics which have in modern times swept over the civilized portion of the globe.

The ability of the cholera germ to exist on various articles of food, and in various drinks, is next well discussed.

The disease is then considered in its relations to the human body—its symptoms, and the conditions which favor its invasion.

The treatment of the 3 stages is next described; then the sanitary and hygienic preventives. Treatment of ship-outbreaks, quarantine and disinfection close the book.

The introduction of culture-methods of diagnosis is unnecessary for lay readers.

*Gray's Anatomy, New (13th) Edition.* Another edition, the thirteenth, of this standard work is announced for early publication by Messrs. Lea Brothers & Co. "It is hardly too much to say that this work has been the most popular of all medical text-books whatever since its first appearance in 1851. Its text has been revised successively by the foremost anatomists of a generation, and the present edition embodies whatever changes were necessary to make it represent its advancing science. The illustrations have always been noted for their clearness. Their large size has rendered it possible to print the names of the parts directly upon them, thereby indicating not only their names, but also their extent—a most important matter. A liberal use of colors has been made to secure additional prominence for certain parts. Notwithstanding these improvements, the constantly increasing demand has justified a reduction in the price of the colored edition. An early review will appear in these columns.

### Medical Progress.

#### TO KEEP THE SKIN HEALTHY.

The following suggestions in the daily press, based upon the experience of one who has made a personal study of the matter, are worthy of consideration by the physicians; especially at this period when the sun's rays are so irritating to the skin:

Now comes the answer to the question,

"How shall I manage from the time I leave home until I return to keep up with all the little arts of my dressing-room?"

Take along with you powdered borax for one thing, a bottle of alcohol, and to this add eau de cologne, benzoin, lime water, olive oil, cucumber cream, ammonia, a little myrrh, the best of powder and the best of soap—castile, white, is a good standby. With a lot of face rags made of Turkish toweling, and your own towels, you can keep as sweet and clean as if you were right at home.

A little alcohol stove gives you warm water when you are so placed that you cannot obtain it in any other way. A big piece of fine white flannel toweling or a rubber flesh brush must be well lathered with the castile. After each pore has been opened your skin is ready for a delightful rinse in water in which either benzoin, cologne or alcohol has been dropped.

I keep on hand a flask of liquid made of one quart of rose water and two drachms of tincture of benzoin. A teaspoonful in a basin of water is very refreshing when used as a body rinse or merely as a face bath. It tightens the skin and gives it a delicate perfume that is extremely taking.

It is absolutely necessary for a woman who wants to have a decent skin to bathe daily during the summer. This she can do in the morning or at night. The habit must be regulated according to her needs. Some ladies prefer one hour, some another.

Always wash the face before retiring. Good soap, warm water and gentle friction will prepare the skin for the second water, in which is dropped, if the complexion has a dull look, something stimulating—a little gin, one of the toilet vinegars or cologne. Don't fall into the habit of picking up eatables during your

morning ramble. It is the nibblers who come home from an outing killed up with dyspepsia. Three meals a day, and as good as you can get, with a bed-time lunch thrown in, will straighten out matters for you in fine style.

You want to use on your face, neck and hands plenty of cream. Don't be niggardly with it, especially at bed time. Spread over your pillow a clean linen towel, and then you can allow the cream to remain on in generous quantities. If sunburned it is absolutely necessary that you soothe your skin. When tan is the trouble you may be as barbarous as you please. Lemon juice is one form. It smarts, tingles and makes some women almost wild. So you see it would be agony to try this harsh remedy for a sun-blistered face. Dry skins must be liberally creamed. Oily complexions cannot bear this treatment. Refine them with your benzoin, alcohol, cologne or borax, using only a very little of each and using this quantity at different times. A cosmetic of any kind loses its efficiency when run too long.

Some women have great faith in powdered nitre dipped into water and applied to freckles. Buttermilk is no account in the world unless you are given the run of a dairy, and even then I consider the remedy far worse than the disease.

And now how about making up. If exposed to the glare of the sun do not hesitate to do so. By this I mean never allow your face to be exposed to wind or sun unless you first wipe it off thoroughly with cream and, when all traces of it have been removed, powder. This acts as a mask.

I always wear a veil simply because I



feel when out in the sun an uncomfortable sensation if not veiled, but there are as many minds about this as there are veils to wear. If you are going to be exposed to sun and wind do not make the mistake of putting on a beautifier in dotted tulle unless you are prepared to suffer the consequences. Try what a little care will do in all directions. In this you may be able to return to your homes not only benefited by your outing, but with the satisfactory feeling that it is not going to take a lifetime to repair complexion damages.

#### THE COLLEGE OF PHYSICIANS AND SURGEONS.

A new medical university has just been organized in the city of Richmond, Va., under a liberal charter granted by the court during the past month. The capital stock is not less than \$20,000 nor more than \$300,000. The corporators are many of the best known of business and professional men of Richmond and vicinity. Among them we notice the names of such men as Major Lewis Ginter, James B. Pace, P. H. Mayo, Charles Watkins, E. D. Taylor, T. C. Williams, Col. C. O'B. Cowardin, Rev. Dr. Moses D. Hoge, Dr. Hunter McGuire, Dr. Joseph A. White, Col. A. S. Buford, Professor Edmund Harrison, Dr. William W. Smith, of Randolph-Macon College, Judge George L. Christian, Hon. J. Randolph Tucker, Col. B. B. Munford, Stephen Putney, Joseph Bryan, E. A. Saunders, Jr., Josph Cullingworth, D. O. Davis, John Pope, R. L. Brown, F. S. Myers, Thomas Atkinson, Thomas Potts, etc. Such names look as if real push and business were behind the movement, especially when

we learn that the Board of Corporators has already held several largely-attended and enthusiastic meetings, and has at work excellent committees to report to a full meeting within a few days. Dr. Hunter McGuire is President, Dr. Joseph A. White is Secretary, and the Virginia Fidelity and Safe Deposit Co. will serve as the Treasurer of the Board. The college will be a three-terms institution, chiefly on the graded plan, as recommended by the Association of American Medical Colleges, and will in every way strive to take first rank among the prominent colleges of the country. Its university feature consists in the fact that, under well chosen professors, there will be a thorough School of Dentistry and a School of Pharmacy, as well as the School of Medicine.

It will be a three-years' graded college, comprising the following departments: Medicine, Thomas J. Moore, M. D., Chairman; Dentistry, Lewis M. Cowardin, M. D., D. D. S., Chairman; Pharmacy, T. A. Miller, Ph. G., Chairman.

An important feature of the College of Physicians and Surgeons will be the establishment of hospitals and dispensaries and the utilization of suitable material for clinical purposes. Indeed, it is proposed, as far as practicable, to illustrate the lectures by cases in point, laboratory experiments and demonstrations, etc.

That the success of the College of Physicians and Surgeons, Richmond, Va., is assured, is indicated by the large number of students who have already expressed their purpose to attend the first session, which will begin October 3, 1893.

### MITRAL REGURGITATION IN ANÆMIA.

In the *International Med. Mag.*, May, Dr. Hersman gives an interesting article upon this subject. He says:

Balfour would explain the ordinary anæmic murmur by supposing that there is a dilatation of the mitral orifice with regurgitation, and that the murmur in the second left intercostal space is the bruit of mitral regurgitation heard in the left auricular appendix. However this may be, it is in no wise improbable that anæmic mitral insufficiency is quite common. The lesions found in the heart warrant such an assumption. In those dead from anæmic conditions fatty degeneration is found in the heart-muscle, in the endocardium, and in the intima of the vessels. Indeed, Perl produced such lesions by inducing an artificial anæmia by repeated venesections. Starting from this pathological basis, it is not difficult to see how a relative insufficiency may occur in one of two ways. The office of the papillary muscles is to prevent a backward bellying of the cusps of the valves under the stress of the blood-current, just as sheets hold a sail in the face of the wind. This is accomplished by an appropriate contraction of the papillary muscle as the ventricle shortens in systole. Now, if a fatty degeneration occurs in these muscles they no longer perform their functions, and with each contraction of the ventricle they are swept backward, and a portion of the blood passes through into the auricle. The same thing may result in another way. If a considerable fatty degeneration occurs in the ventricular walls they lose their elasticity and resisting power, and become dilated by

the blood-pressure. Their support is thus removed from the auriculo-ventricular ring, which also spreads, pulling apart the cusps of the valve, and thus allowing regurgitation to occur. Of course, where these two factors are combined, a still higher degree of insufficiency will result. In the most of my cases there was marked œdema of the ankles and legs. Œdema is of common occurrence in chlorosis, and has been interpreted by some as indicating a permeable condition of the vessel walls brought about by malnutrition. In the cases reported in this paper the cause of the dropsy does not seem to me to be more obscure or more difficult to explain than that œdema common to mitral insufficiency. Indeed, it owns an identical cause, being the definite result of a temporary mitral regurgitation. And I believe that many cases of this chlorotic œdema depend more directly on the state of the heart than upon the condition of the blood. It is a common experience that an organic lesion of the mitral may exist, followed by dropsy and other results of stasis, and yet no murmur be detected; and I have thought that in some of the anæmic dropsies, where no murmur indicating a relative mitral insufficiency could be detected, perhaps here, too, was a leak with no murmur.

It seems to me, from a study of cases, that we may justly draw the following conclusions:

*First.* A murmur, systolic in time, heard with greatest intensity at the apex, conveyed to the left and audible at the inferior angle of the left scapula, does not necessarily indicate an organic mitral insufficiency.

*Second.* In those cases where the

question of differential diagnosis arises there are no signs which will enable us to distinguish, certainly and at once, between an organic mitral insufficiency and the temporary form found in anæmia.

*Third.* Some cases of organic, by which I intend to imply incurable, mitral insufficiency, in which no history of rheumatism, or other recognized causes of such a condition, can be obtained, may have originated in anæmia, for it is conceivable that the muscular degeneration may reach such a degree that entire recovery is impossible, or a valve may be so altered by the fatty change that its integrity can never be restored.

#### PERTUSSIS TREATED WITH BROMOFORM.

In the *Archives of Pediatrics*, July, Dr. Kerley reports the following cases: Three children aged respectively eight, six and four years, members of the same family, developed pertussis within a few days of each other. They came under my observation at the Babies' Hospital at the onset of the disease, in fact, before the diagnosis was absolutely positive. Pertussis was strongly suspected, however, and they were put on the bromoform treatment at once, which drug has been used in the management of this affection by many observers with widely varying results. It is claimed by some that if bromoform is given early, the disease may be aborted, by others that the number and severity of the paroxysms will be diminished, and the duration of the attack shortened. Equally good observers, on the other hand, state that after a fair trial the drug proved itself valueless in their hands.

Concerning the cases in question the youngest, a decidedly rhachitic girl of four years, was given five drops four times daily, the other two, fairly healthy boys, each received six drops four times daily. Under the treatment the disease developed apparently about equally severe in all. The paroxysms varied from fifteen to twenty daily; vomiting occurred frequently during the second week, during which time the disease was most severe, the patients presenting the typical appearance; the eyes congested and the faces puffed and swollen. At about the eighteenth day of treatment the disease began to subside, the number and severity of the paroxysms diminished rapidly, the vomiting ceased, and at the end of the fourth week, greatly to my surprise, they were practically well as far as the pertussis was concerned.

No other drug was used. Whether the short course and sudden subsidence of the acute symptoms were accidental or due to the treatment, I will endeavor to clear up by further trial.

#### RED SWEAT.

In the *University Medical Magazine*, July, Dr. Hartzell, after relating some cases which have come under his care, sums up the subject as follows: Although this malady has been known for some time, its true nature has only been determined within a comparatively recent period. Hoffman and Pick, in Germany, and Babes, in France, first pointed out that the red color was due to a fungus growing upon the hair, which the last-named author succeeded in cultivating upon coagulated albumin. The pigment, according to Babes, who examined it spectroscopically, resembles



that produced by the *micrococcus prodigiosus*, the fungus concerned in the production of the so-called "bleeding host." The identity of the two organisms, however, has not yet been proven. By scraping the epidermis in the axillary and perineal regions, organisms similar to those upon the hair have been found, but not all of these were pigmented—many of them were colorless. Balzer and Barthelemy, who have also studied the matter carefully, are of the opinion that it is much more frequent than is commonly supposed, since they were able to collect a considerable number of cases by examining individuals at random. The pigment is not always red, but may be of a yellow hue, and these authors found instances in which the parasite was present upon the axillary hairs without any pigment accompanying it. In most cases the sweat is usually abundant, but is not yet known whether qualitative changes in this excretion are necessary for the production of the disease.

It would seem that blondes are more frequently affected than brunettes, and that weakness and debility are predisposing conditions, although the robust are not exempt.

As has already been mentioned, the sweat is colorless upon its excretion, and for this reason the name chromidrosis should be abandoned; the malady is, in fact, one of the hairs, and not of the sweat-gland.

As the disease is not attended with any annoying symptoms, treatment is rarely sought unless the staining of the underwear is considerable. In the writer's cases alcoholic solutions of bichloride of mercury, two to three grains to

the ounce, were employed as lotions with some degree of success; but much more speedy results would probably be obtained by first shaving the affected regions, as in this manner a large part of the fungus would be removed at once.

#### FOREIGN BODIES IN CHILD'S WINDPIPE.

In a lecture on the surgery of the air-passages and thorax in children recently delivered at the Royal College of Surgeons of England Dr. Pitts, of St. Thomas's Hospital, said (*Brit. Med. Jour.*, July 22).

The symptoms attending the introduction of a foreign body into the air passages, and its lodgment there, are so well known that a recapitulation of them is unnecessary. On most occasions the diagnosis is clear, but occasionally, in the absence of history, and from special peculiar features in the case, it is very difficult to arrive at any certain conclusions. On the other hand, the history of swallowing a foreign body may be imaginative on the part of the friends, and have nothing to do with the case under consideration. When we remember how constantly children are running about at play with some foreign body in their mouths, and how often they laugh or cry quite suddenly in the midst of eating their food, it is remarkable that the accident does not more frequently occur.

When a foreign body is impacted in the larynx after the initial paroxysm has subsided, the symptoms may be very slightly marked, though usually there is alteration of voice, some cough and dyspnoea, with pain and tenderness about the larynx. The difficulty of diagnosis in very young children may be very

great. Occasionally even in children the foreign body may be seen with the laryngoscope. If a foreign body remain in the larynx it may at any time prove fatal by giving rise to inflammatory œdema of the glottis; or, as shown by cases narrated, the ulcer may occasion pneumonia. The body may be expelled by coughing, or change its position, and pass into the trachea or one of the bronchial tubes. If it remains for a prolonged period in the larynx the voice is likely to be permanently affected, and such stenosis of the larynx may result as to necessitate the wearing of a tracheotomy tube.

When a foreign body is lodged in the trachea there are usually signs of its presence on auscultation, and the recurrent attacks of dyspnœa, as the body changes its position, are very characteristic.

A small smooth body, especially if heavy, is more prone to descend into one of the bronchial tubes than an uneven light body, which is likely to remain in the trachea. The tendency of the body to pass into the right bronchus rather than the left has generally been ascribed to the fact that the septum at the bifurcation is somewhat to the left of the middle line. Dr. Alby, of Rome, has demonstrated that the right bronchus more closely follows the line of the trachea than the left. It is probable that foreign bodies find their way into the left bronchus much more often than is generally supposed. There appears to be a good deal of difference of opinion amongst the compilers of statistics as to which bronchus has the preference.

When a foreign body enters one of the bronchi, the symptoms produced must

vary with its size, position, and character. Thus, if it completely blocks the main bronchus, the proper respiratory sounds are absent. If it partially obstructs, then a musical sound is likely to be heard, with diminished breathing in the lung of the affected side. There is generally pain, cough, and perhaps some blood-tinged expectoration. The affected side is at first resonant on percussion. If the body be impacted in one of the secondary divisions, then only a limited area of the lung will at first be affected.

If a foreign body remain impacted in a bronchus, inflammatory symptoms generally supervene, and may be localised or general. The results are very variable. Both the bronchi can be easily explored from a low incision in the trachea, and many cases are on record where various substances have been thus removed successfully in children, and much ingenuity has been exercised to meet the mechanical difficulties in particular instances. Death may result both after the removal by operation and after its spontaneous ejection. In several recorded cases where an unsuccessful search has been made, the tracheotomy wound has been left open and the body ejected at a later period. When an abscess forms in the lung, recovery is very rare. The usual mode of death in obstruction of bronchus by foreign body is pneumonia with abscess or gangrene. Death may, however, take place quite suddenly from the body getting displaced from the obstructed to the sound side.

#### SPLENOMEGALIA.

In a lecture upon Essential Hypertrophy of the Spleen, delivered at the

Necker Hospital, of Paris, Dr. Render (*International Medical Magazine*, May) said:

In practice, nothing is more obscure than these hypertrophies of the spleen.

Most often they are very slow in formation, as in our patient. The functional troubles that are first seen do not enable you to determine the correct cause. I saw a case in a young man of fourteen who commenced by complaining of poor digestion, and for a few days could not take either liquid or solid food, then for ten or twenty days he could eat anything he liked. Afterwards he was found with a large spleen, from which he finally recovered. Again it will be the lungs that seem at fault. There is a pleuritis or else a pulmonary congestion at the base of the trouble, and here, I think, the enlargement of the spleen is a reflex action. The sub-diaphragmatic region is very rich in reflexes. I can only in this way explain a pulmonary congestion that comes on from a biliary calculus.

Finally, there is the action on the kidneys. I was called in consultation to see a patient who was dyspeptic, who urinated with difficulty, and had at one time hæmaturia, later polyuria, and six months afterwards an enormous spleen. During the stationary period of this malady it seems to be benign in character.

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### Medical Items.

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Dr. Thomas Opie has removed his office from 600 N. Howard St. to 216 W. Monument St., near Howard Street.

Dr. Wenzel Kopfsstein, of Prague, reports the successful implantation of cancerous tissue in the brain of a rabbit.

At the last government examination in Japan for license to practise medicine and surgery, 4,270 candidates presented themselves. This is a larger number than the total graduated from American medical colleges.

Dr. William Goodell, professor of gynaecology in the University of Pennsylvania for many years, has resigned. The trustees accepted his resignation "with regret," and elected him honorary professor of gynaecology, with the right of lecturing.

"But Doctor," insisted the opinionated lady patient, "don't you know that it has been proven that diphtheria and dysentery are the same disease?"

"No madam. I assure you not," was the answer. "They are at different ends of the body."

Dr. Moore, of Camden, S. C., reports in the *Virginia Med. Monthly* a case in which a mother lost the power of speech after bearing twins, and had not regained it fully two months later. She seemed well for two weeks after delivery, then had headache, became unconscious for 3 days, and on regaining consciousness was aphasic.

Dr. John E. Gorsuch died August 28, at his home, 1133 E. Fayette St., after a short illness. Dr. Gorsuch was fifty-four years old. He was a son of the late Benjamin Gorsuch, of Mt. Carmel, Baltimore County, Md. His wife was



traveling in the West. Dr. Gorsuch left no children.

Maryland physicians appointed by Gov. Brown as delegates to Pan-American Medical Congress are Dr. R. E. Brumwell, Cecil Co.; Dr. Frank Hines, Kent Co.; Dr. Jackson Piper, Baltimore Co.; Dr. Wm. H. Balzell, Frederick Co.; Dr. J. M. Wellington, Anne Arundel; Dr. J. A. Stewart, and J. F. McShane, Baltimore City; Dr. C. A. Wells, Prince George; Dr. Thomas Owings, Howard Co.

Medical Proverbs.—Tender surgeons make foul wounds. Of the malady a man fears, he dies. Diseases are a tax upon our pleasures. He that would be healthy must wear his winter clothes in summer. He that sits with his back to a draft sits with his face to a coffin. A good surgeon must have an eagle's eye, a lion's heart, and a lady's hand.—*Practice.*

The profession of Baltimore will regret to learn of the death of Mr. A. R. Carter, Secretary of our Health Department.

Some time ago he was seized with faintness while laboring at his post in the City Hall. In spite of removal to Mountain Lake Park he became worse, and died there August 25th. Mr. Carter was well known to physicians of Baltimore as a most faithful worker, deeply interested in sanitary affairs.

The following bacteriological anecdote, appropriate to the season, may serve to illustrate the value of common sense in the kitchen. "Bridget," said the mistress of the house, "I wish you to boil all our drinking water, after filtering it. There are little creatures called bacteria in the water in summer, which cause disease, and the boiling kills them. "Sure

miss" replied Bridget, "I think I'll boil the water first and filter it afterwards; for after we have killed the bastes we'll *have need* to filter them out, when they're dead corpses, so we will."

We learn with regret through the daily press of the death of Dr. George W. Benson, formerly Health Commissioner of this city. He died August 22, at his home on Hanover St., of Bright's disease. He had been failing in health for a year and had been confined to his home four weeks. Dr. Benson was born at Princess Anne, Somerset County, Md., in 1831. He came to Baltimore when seventeen years of age, and served an apprenticeship in a drug store during three years, in which he also studied at the Maryland University. He was graduated in medicine from the University in 1851 and began the practice of his profession, which continued up to the time of his last sickness. Dr. Benson was appointed coroner in 1856, and was appointed health commissioner of Baltimore in 1872 by Mayor Joshua Vansant. He was reappointed health commissioner by Mayor William Pinkney White in 1882. Dr. Benson resigned at the end of his second term as commissioner. Smallpox epidemics marked both of his administrations of the health department. Dr. Benson was twice married. His first wife was Miss Susie E. Dexter, of Chelsea, Mass., who died in 1875, leaving a son, Morton, who is living. His second wife was Mrs. Walter Waite, who has a daughter by her former marriage. His widow and son survive him. Dr. Benson also leaves a brother, Dr. P. V. Benson, of Baltimore, and a sister, Miss Laura Benson, of Annapolis.

The College of Physicians and Surgeons of Richmond, Va., was organized in May, 1893. with schools of Medicine, Dentistry and Pharmacy. It will give a three-year graded course in medicine beginning October 3rd, 1893. The members of the Faculty of Medicine are:

Hunter McGuire, M. D., LL. D., Professor of Clinical Surgery; Hugh M. Taylor, M. D., Professor of Practice of Surgery; Stuart McGuire, M. D., Professor of Principles of Surgery; Landon B. Edwards, M. D., Professor of Practice of Medicine; Thomas J. Moore, M. D., Professor of Clinical Medicine; Edward McGuire, M. D., Professor of Diseases of the Nervous System, and Associate Professor of Diseases of Women; George Ross, M. D., Professor of Obstetrics; Isaiah H. White, M. D., Professor of Diseases of Women; Paulus A. Irving, M. D., Professor of Diseases of Children; Lewis Wheat, M. D., Professor of Diseases of the Genito-Urinary Organs and Syphilis; Joseph A. White, A. M., M. D., Professor of Diseases of the Eye, and Associate Professor of Diseases of Ear, Throat, and Nose; John Dunn, M. A., M. D., Professor of Diseases of Ear, Throat, and Nose, and Associate Professor of the Diseases of the Eye; Jacob Michaux, M. D., Professor of Materia Medica and Therapeutics, and Clinical Professor of Diseases of the Rectum; William S. Gordon, M. D., Professor of Physiology; J. Allison Hodges, M. A., M. D., Professor of Anatomy; M. D. Hoge, Jr., M. D., Professor of Histology, Pathology and Urinology; Chas. H. Chalkley, M. D., Professor of Chemistry, Toxicology, and Medical Jurisprudence; W. T. Oppenhimer, M. D., Pro-

fessor of Hygiene and State Medicine, and Clinical Professor of Skin Diseases.

Dr. William Haslet Clendinen died this week at his home, 201 N. Broadway. He had been sick for seven months from stomach troubles, most of the time confined to his room. For twenty-five years Dr. Clendinen had been a prominent practitioner in East Baltimore, and had a high standing in the medical fraternity. He was over sixty years old, and was a native of Baltimore. His father, Wm. Haslet Clendinen, Sr., was an eminent East Baltimore physician, as was also his half-brother, Dr. Alexander Clendinen, both of whom received praise for their conduct in the yellow fever epidemic of 1819-20. Dr. Wm. Clendinen was graduated from the University of Maryland in 1850. From 1862 to 1865 he was the quarantine physician for Baltimore. He was also put in charge of the temporary barracks erected on the quarantine grounds for the small-pox patients from the Union army, receiving from the government a commission as acting assistant surgeon in the army, with the rank of major, August 5, 1861, which he held until the close of the civil war. Mayor Chapman in his message commended Dr. Clendinen's management of the quarantine hospital, the duties of which at that time were peculiarly arduous. In 1854 Dr. Clendinen founded a dispensary at St. Barnabas' Protestant Episcopal Church, which he served as attending physician and conducted for two years, after which it was removed to the Church Home on N. Broadway. Dr. Clendinen was not married.—*Ex.*

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### Original Articles.

#### A CASE OF DELAYED UNION AFTER FRACTURE.

BY PEARCE KINTZING, M. D.,  
OF BALTIMORE.

On the seventh of February, of the current year, Henry A., while driving for the Traction Company, was thrown from a heavy cart, the wheel of which passed over his leg. He walked a square after the accident, fell to the ground and was conveyed home in the patrol.

Not until twenty-four hours later did I see the case. I found a fracture of both tibia and fibula. It was thought at the time that the fracture of the tibia was double, but as the contusion was very extensive, and the swelling had at this time reached its fullest capacity, this de-

cision was by no means certain. The leg was put into two straight splints, and left until next day. The habits of the patient were essentially most vicious. When seen he was intoxicated to what, had the case been one of uterine proce-  
*dentia*, would be denominated *the third degree*. He had been an inveterate drinker and smoker, and during these first days smoked almost incessantly. He confessed to being syphilitic and had several nodules on the tibia, following an injury, about a year previously. The cavity left after removal of a seques-  
*trum* could be plainly felt.

Next day it was found that the patient had been out of bed, and had been freely drinking of gin. A small opening through the skin, leading down to the bone, was now found. There were also numerous blisters scattered about, filled



with serum. These were evacuated. The opening was sealed up without any washing, as it kept oozing slightly, with benzoin on gauze, and the leg surrounded with cotton, and a plaster cast adjusted from the toes to the knee—made very thick and strong. He was kept in bed by force and an attempt was made to deprive him of gin and tobacco, but with indifferent success.

During three days the cast caused so much pain that it was removed. The opening had closed completely, and gave no further trouble; the bones were in excellent apposition, but numerous blisters had formed. These were incised, a flannel roller adjusted, and the leg placed in a fracture box. The bed was a lounge and two chairs; the mattress, old pillows, folded clothes and old carpets; and the utmost difficulty was experienced in controlling the patient.

Examinations showed the deposit of considerable callus, and everything looked favorable. At the end of six weeks, careful passive motion was begun in the knee and ankle and kept up daily. The callus rapidly disappeared, and in three days the leg at the seat of fracture could be bent as easily as an ordinary wrist joint. There was no union whatever. Lime water was then administered after Prof. Ashhurst's plan, and fifty grains iodide potassium given daily, and motion discontinued. Dire vengeance was threatened any one who supplied whiskey or tobacco, and seemed to have had some effect. At the end of the tenth week there was no improvement and the case looked hopeless. There was no callus nor inflammatory sign, so wiring was determined upon, but owing to circumstances had to be postponed

one week. At the end of the eleventh week there seemed to be some callus, and operative interference was again deferred. At the end of the twelfth week, strong friction was used daily for three days, the leg put in a cast and crutches provided. There was as yet only a suspicion of approaching union, and free movement could be made. After the patient began to go about, swelling recurred, callus was freely deposited, and improvement was rapid. Crutches were discarded by the end of May. Now the patient is at work, the leg is fully as strong as its fellow, all without any operative interference.

601 W. Franklin Street.

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### A SUMMARY OF ELECTROTHERAPEUTIC WORK IN A PRIVATE HOSPITAL.\*

BY G. BETTON MASSEY, M. D.

The recent growth of private hospitals devoted to abdominal surgery and other operative procedures deserves attention as indicative of an increased appreciation on the part of the profession of the responsibilities of its work. These numerous institutions have arisen in response to a real need. The conscientious surgeon is no longer content to subject his patient and his reputation to results necessarily attending operations in offices, private houses, hotels, and public hospitals, the latter primarily intended for alleviation of the poor. A refinement of technique that would insure the best results required the creation of a machine adapted to the highest quality of work.

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\* Read before the Philadelphia County Medical Society.

It is not a little surprising that this most ordinary provision of a proper means for effective work in relieving and curing human suffering should have been so long neglected by the medical profession, while the meanest trades that minister to the wants and vanities of the race have been housed in light and airy apartments, specially arranged for their proper and convenient prosecution.

The private hospitals for major operations have come and have justified themselves. An extension of this sensible idea now presses upon the profession. If major surgery and the surgery of last resort needs this environment for its success, why should we neglect to supply analogous armaments to the work of curing diseases by conservative means?

There is, in fact, a double reason for such establishments; for the re-enforcement and enlargement of our power to actually cure diseased organs not only lead to greater success in such high work, but lessen our need to resort to the cruder methods of amputation and removal of parts of the human body yet capable of restoration to health.

An establishment thus devoted to the highest development of the possibilities of electricity and allied agencies in medicine and surgery has, therefore, a reason for being in the mere fact that to be well equipped is an important part of the battle in any special line of medical study and art. It has also a reason for existence, more peculiar to itself, in the fact that the principal remedy in its equipment is itself in a transition state, and yet but imperfectly understood. To understand and in the most successful manner apply what is already known of the remedy requires technical knowledge of no mean

extent, costly apparatus, and particular facilities; and when the extension of our knowledge of the agent is also considered, the value of enlarged facilities is even more evident. It is true that many of the uses of electricity in medicine may be prescribed and applied by a physician without an extensive knowledge of the agent, just as he prescribes a ready-made pill; but the highest possibilities of the advancement of therapeutic knowledge in this way are as impossible as that a mere user of the telephone could have done Edison's work.

Such were the considerations that determined the establishment of a private hospital for the development of electrotherapeutics in this city; and the cordial co-operation in the work by many members of the profession has already enabled me to present a brief summary of the results accomplished.

A variety of cases have been under treatment, in the majority of which electricity has formed the principal therapeutic agent, though a not inconsiderable number have received electrical applications as a secondary part of the treatment; rest, massage, regulated exercise, and internal medication being associated with them.

*Fibroid Tumors of the Uterus.*—Twenty cases of myofibromata of the uterus were admitted, presenting many variations of the affection. Of the twenty cases, fifteen were of the ordinary solid varieties, to which the Apostoli method is now generally regarded as applicable.

The results attained in these fifteen cases of solid interstitial and sub-peritoneal growths were: No further growths occurred in any, and a complete symptomatic cure was obtained in each. Of

these fifteen tumors thus symptomatically cured, two were also anatomically cured, the growths disappearing entirely in each; ten were greatly reduced in size; two slightly reduced in size, both being still under treatment; and one was not affected as to size.

The five remaining cases were all intra-uterine growths, two being solid polypi with small pedicles. The latter were brought into the vagina by the use of faradic currents and ergot and removed by torsion and division, after which the cavity of the uterus was treated by intra-uterine galvanic currents to prevent the development of other nuclei. Three cases were cystic intra-uterine growths of the most formidable kind described.

It is well-known at present that cystic growths, as a rule, are not amenable to electricity, and after attempting relief by external methods in one of these, a lack of success caused me to refer it to a surgeon. The second intra-uterine cystic growth, forming a tumor as large as an adult head, having been referred to me by a prominent surgeon, was treated by the intra-uterine method with unfortunate results, owing to a failure to maintain asepsis. Death resulted from septicæmia two weeks after admission into the private hospital, as elsewhere reported, the sepsis having been received during office practice.

The third intra-uterine cystic tumor, and the final one of this list, was almost an exact counterpart of this fatal case, though the spongy intra-uterine mass was vascular. This lady was sent to me by a surgeon who recognized the difficulties attending hysterectomy with a wildly dilated cervix, even if she had

consented to operation. After mature deliberation and attempts to enucleate piecemeal, which were desisted from owing to frightful hæmorrhage, I decided to apply strong necrosing currents (from 400 to 600 milliamperes) directly to the presenting portions of the mass at the external and internal os, being convinced of my ability to maintain a reasonably aseptic condition by continuous irrigation, a suggestion which I owe to Dr. Slocum. These currents, applied after the bi-polar methods, practically dissolve tissues in the immediate path of the current, and produce a coagulated condition of living tissue at the periphery of the destroyed part, that in itself is a bar to septic absorption for a time. Under this treatment the whole tumor was gradually removed, without a drop of blood, as a rule, and at the present time the uterus is almost normal in size.

Reserving an opinion on the future of electricity in cystic growths of the uterus, it will be seen that these statistics do even more than corroborate Apostoli's claims, for in at least two of the cured cases the tumors disappeared completely by absorption.

*Chronic Metritis.*—In spite of the prevalent impression that chronic catarrhal metritis is a rare disease and relatively unimportant as compared with inflammatory conditions of the appendages, eight cases admitted into the institution were diagnosed as suffering primarily from this affection. In seven of these the diagnosis was corroborated by the therapeutic evidence of relief of symptoms and restoration of health after cure of the local disease of the uterus. Each of these cases of cured metritis, and one case not relieved, with a single excep-



tion, showed a general impairment of the health amounting in some cases to pronounced nervous prostration, and in the treatment employed the disturbance of the nervous system received ample recognition. Mere office treatment with electricity would doubtless have been unavailing in such cases. The nervous symptoms demanded their share of attention; yet had not a gynæcological electrical treatment been associated with the rest, massage and general electricity, a failure to relieve would have been equally certain. This class of cases is a continual reminder of the need of the practical association of a gynæcological and neurological training in the worker in the diseases of women. The physical and the nervous woman are conjoined by nature in both health and disease, and no mere nosological classification will separate what nature has thus joined together.

Two of these cases were samples of that unfortunately increasing number of women whose relatively normal ovaries have been removed for what was really uterine disease, and I regret to say that the only instance of failure to attain a practical cure was in one of these. A persistent uterine leucorrhœa had continued in this case two years after removal of both ovaries. The discharge was purulent, and emitted an odor so unusually offensive, though unlike that from carcinoma, that I suspected its origin to be an infected ligature at the uterine end of one of the cut tubes.

*Neurasthenia, Hernia, and Nervous Prostration.*—Seventeen cases of the allied affections of neurasthenia, hysteria, and nervous prostration were ad-

mitted to the institution, and in their treatment electricity was made to take a more important role than is usually given it. Recognizing the self-evident fact that nutritive disorders play an important part in the pathology of these affections, and that in some of them the real affection is an auto-intoxication of the system from imperfect action of the organs of digestion, assimilation, and excretion, these organs and their controlling nerve plexuses were subjected to the actions of galvanic currents of an amperage hitherto unused in such methods. The results have proven the great value of this modification of the rest treatment, rendering cases amenable to it that were failures under the severe stress of mere enforced rest, seclusion, and massage. Experience has dictated also that the faradic current usually employed in these cases as a general muscular and sensory stimulant is best replaced by the galvanic current applied with a large flexible pad as active electrode, well soaped to render its labile action agreeable. The surface reaction is far greater than that possible in the usual faradic method, and to this is added a stimulation of deeper structures by direct chemical changes that is possible only with this current.

*Perimetritic Inflammation.*—Two cases of perimetritic inflammatory deposits associated with the adhesions of old pelvic peritonitis were admitted and treated mainly by the vagino-abdominal method. The most successful result was attained in the case in which the cataphoretic transmissions of iodide of potassium through the parts was used in connection with the current, old adhesions being loosened, and painful cellutic de-

posits and enlarged tubes rendered painless and reduced in size. The addition of a resolvent agent so well known as iodine to the absorbent action of the galvanic current cannot be other than extremely valuable in this class of work.

*Malignant Growths.*—Two cases of sarcoma of the fundus uteri were under treatment for a time, without results that amounted to more than moderate palliation. If electricity has a field of usefulness in carcinoma, it is only when the seat of disease can be more readily reached, as in such cases as cancer of the cervix. An experience gained elsewhere convinces me that the palliative effects of electricity in cancerous conditions of the cervix are very valuable, and that they may even be curative when the disease is still distinctly local.

*Desquamative Enteritis.*—Three cases admitted into the institution suffering from prostration and chronic invalidism, supposed to be due to disease of the uterus and ovaries, proved to be instances of desquamative enteritis. One of these had been treated for fifteen years for ovarian disease by one of the most prominent practitioners in the country, without the true nature of the disease being suspected, and another had been mistakenly diagnosed and treated for five years. A study and examination of the stools, which is invariably made in obscure cases, revealed the true character of the trouble—a chronic desquamative inflammation of some portion of the intestinal tract, usually the colon. In one of these a pulsating tumor lay in the left hypochondriac region, doubtless consisting of thickened membrane and enlarged glands lying over the abdominal aorta. In another case the pulsation

was also manifest; and all the cases were bronzed to a varied degree. One was discharged much improved by a treatment consisting of the nitro-hydrochloric acid, arsenic, external galvanic currents, and regulation of the diet, and two cases are improving under treatment of a similar character.

My experience in this affection has convinced me that many cases remain undiagnosed by physicians who neglect to avail themselves of the signal aid given in obscure chronic diseases by systematic examination of the alvine discharges.

*Miscellaneous.*—Other cases admitted presented instances of ovaritis, menorrhœalgia, chlorosis, pernicious anæmia, obstruction of the bowel, meningitis, chorea, multiple neuritis, musculo-spiral spasm, hemiplegia, locomotor ataxia, etc., in some of which excellent results were obtained; but as the number of each was limited, no general deductions from them will be presented at the present time.

While it is generally true that a physician's bill for treating the wife is the debt of the husband, the Supreme Court of Indiana says in the case of the City of Columbus v. Strassner, that it perceives no reason why she may not treat it as her own debt and pay it. It can make no difference to a third party liable to reimburse the one paying it whether it pay such bill to the wife or to the husband. If the wife pays it out of her own separate means, the husband cannot recover it from such third party, so the latter is in no danger of being compelled to pay it more than once.—*Cincinnati Lancet Clinic.*

## MARYLAND MEDICAL JOURNAL.

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BALTIMORE, SEPTEMBER 9, 1893.

**Editorial.****TO MAKE SOCIETY MEETINGS  
ATTRACTIVE.**

With the advent of the autumn the committees of our medical societies begin to plan the work of the coming session and to engage articles for the meetings.

It is a serious question whether the ideal program for these assemblies has yet been devised, as far as the general practitioners are concerned. In hospitals and among specialists, where there is a stronger bond of interest in the work presented to the society for discussion, it is not difficult to keep up interest. But in the societies of city physicians something more seems to be needed. After the first blush of professional youth the member is prone to yield to the attractions of home and fireside and to "cut" the society meeting, salving his conscience with the plea of fatigue.

The evident value of the practitioner's societies to the profession of the city is such that every effort ought to be put forth on the part of public-spirited members to make them attractive and instructive, and by earnest reflection to find the remedy for that tendency to degeneration and insipidity which seems inherent in all such medical bodies.

Moved rather by the extreme importance of the subject than by consciousness of ability to guide, we call the attention of our readers to the subject and invite suggestions for the improvement of our meetings during the coming season.

One thing certainly needed is that the papers on the programme should be read without fail on the evening for which they are promised and at a specified hour of the evening. Many physicians would then drop in to hear particular papers read and discussed. To secure such punctuality, rules regulating the time allowed for reading and discussion would have to be sternly enforced.

Judging from the full houses drawn together by announcements of papers from certain of the Johns Hopkins workers, decided advantage might be obtained by inviting distinguished men from neighboring cities to read papers on certain evenings during the season upon practical themes of which they have made special studies. We believe that the certainty of meeting and addressing a large company of our city physicians would make it easy to induce many such men to visit and address us in this way.

Our need of an attractive permanent home for the medical societies of this city is evident to all observers.



## TO CUT ŒSOPHAGEAL STRICTURES.

In a reprint from the *Medical Record*, February 25, Dr. Robert Abbe, of New York, presents us with a new method for dilating œsophageal strictures which seems capable of application in the dilatation of other passages of the body likewise. He claims for it superiority to other methods, in that it is more efficient than simple dilatation with bougies, yet does not involve the risks of cutting with the knife.

We may allow him to describe the method in his own words, as applied in his first case. He says: It is to obviate the risks of cutting internally in tough and extensive strictures that I have devised and used the method which I now speak of—namely, cutting with a string the tissues made tense by dilating with a bougie at the time. The principle involved is a commonly experienced one, that even a blunt object like a string, if drawn across a tense tissue (the web between the fingers for instance) will cause a cut to occur which would not take place if the tissue were flabby. Hence the self-limited division of the stricture goes on only so long as the bougie maintains local tension at the site of stricture.

Experience has shown, in the case now cited, that when the dilatation had been carried to its utmost limit by a small conical bougie, a string previously passed through the stricture being drawn back and forth, the dilating bougie could be rapidly advanced where before it had come to a standstill in spite of any legitimate force that had been used.

The case was one of œsophageal stric-

ture in a middle-aged woman following the ingestion of strong ammonia. The obstruction was thirteen and one-half inches from her teeth. From the behavior of swallowed food regurgitating there was every reason to believe there was a considerable pouching of the tube above the stricture. Dr. Fisk kindly transferred her to my service at St. Luke's Hospital, where I operated four days later, December 9, 1892, believing I might possibly do an internal dilatation or œsophagotomy through an opening in the neck. I tried this first, but was utterly unable to pass any instrument through the obstruction, which was five inches below the wound. I then made the usual gastrostomy incision, stitched the stomach to the abdominal wall, and at once opened it. My finger could be passed through this into the cardiac orifice of the œsophagus, and guided thereby I passed a very small conical gum elastic bougie upward with some force, and to its end I secured a piece of heavy braided silk; this I drew out through the wound in the neck. The stricture was extremely dense, and I judged about an inch in length, its lower end two and one-half inches from the stomach. With the thread as a guide, I now endeavored to proceed with dilatation, but found the obstruction too firm to yield. The œsophagus was pushed up by the force, and it seemed as if to use more would tear it across and cause grave damage to its walls. With the conical end of the bougie tightly wedged in the stricture, it occurred to me to assist by pulling the string upward at the neck; then the stricture was felt to yield and the dilator advanced through the mass. Three large bougies

were passed consecutively, and each was tightly crowded in while the string was see-sawed back and forth. The stretching was kept at its maximum, and the bougies passed with remarkable ease the entire length of the œsophagus. The bleeding was practically insignificant. I am perfectly certain that except for this device the stricture could not have been relieved. I made several prior attempts to introduce œsophagotomes, and even the Otis urethrotome, through the stricture from the stomach, but was unable to do so. The patient experienced little or no shock from the operation, and subsequently had almost no fever.

After the dilatation I drew up into the œsophagus to a point higher than the stricture a rubber tube the size of one's finger, and left it *in situ*, the lower end coming out of the gastrostomy wound, thus giving the patient a chance to frequently rinse her mouth and throat with ice-water, which, when she swallowed, poured out of the tube below.

Nutritious food was meanwhile regularly placed in the stomach by another tube. Uninterrupted recovery ensued.

At the end of a week I again etherized her and repeated the free dilatation, the string serving to assist a still larger bougie to pass as readily as before.

This has since been passed without anæsthesia from the mouth to the stomach, and the string has been permanently removed.

The œsophageal fistula in the neck closed spontaneously in two weeks. The gastric fistula was closed later.

Dr. George A. Fleming has removed to 1018 Madison Ave. near Hoffman St., taking the handsome residence formerly occupied by Dr. Dickson.

## Reviews, Books and Pamphlets.

*Mineral Springs and Health Resorts of California;* With a complete chemical analysis of every important mineral water in the world. Illustrated. A prize essay. Annual prize of the Medical Society of the State of California, awarded April 20, 1889. By WINSLOW ANDERSON, M. D., M. R. C. P., Lond., M. R. C. S., Eng., etc., joint editor and publisher of the *Pacific Medical Journal*, Assistant Chair Medical Chemistry and Materia Medica, University of California, etc. 8vo., pages 384. San Francisco: The Bancroft Co., 1892. Cloth.

Believing in the doctrine of "America for Americans," and welcoming every effort, not connected with protective tariff, to develop the infant resources of our marvellous country, we review with interest this handsome volume, which sets forth so clearly the virtues of abounding mineral springs of the great western State.

After a dissertation of 67 pages on the therapy, external and internal, of mineral waters, and the manner in which the springs originate in the earth, the author enters upon a catalogue of the mineral springs of California, hot and cold, describing in detail about two hundred of them. The surroundings of each are given, the routes by which they are reached, their peculiar qualities, and in numerous instances the results of chemical analysis of the water. About two hundred pages are filled in this manner.

The rest of the work deals with the mineral springs of other regions of the United States and Europe; and, in clos-

ing, with the history and climatology of California.

The volume is in clear, large type, very attractive; and is illustrated freely throughout in such a manner as to furnish vivid ideas of California scenery and health resorts.

Dr. Anderson has succeeded in presenting to the profession a treasury of valuable facts, just the thing for the private office table.

*A New Medical Dictionary.* A completely new Medical Dictionary is announced for early publication by Lea Brothers & Co. The author, Dr. Alexander Duane, of New York, is already widely known as the medical expert for Webster's International Dictionary. His new work has been drafted to supply medical students with all desired information concerning the words they will meet in their course of reading, and as the vocabulary has been selected most liberally, the work will be of value to practitioners also. The pronunciation of each word is given by a simple and obvious phonetic spelling; then follows the derivation, an unexcelled aid to memory, and finally a full definition. Descriptive matter has been appended to such words as cannot be adequately explained by simple definition. Thus diseases are described, and their symptoms and treatment are given; drugs are followed by their properties, effects, doses, etc. Extensive tables of bacteria, doses, etc., are placed in the alphabet most conveniently for reference. A work of real value is promised, and we shall take an early opportunity of reviewing it in these columns.

*A New and Safe Method of Cutting Oesophageal Strictures;* by ROB'T ABBE, M.D.,

of New York. Reprint from *Medical Record*, February 25th, 1893. (See Editorial.)

*The Surgery of Gall-stone Obstruction;* (Illustrated by a number of instructive drawings) by ROBERT ABBE, M. D., Surgeon to St. Luke's Hospital, New York; Professor of Surgery at the Post-Graduate Medical School, etc. Reprint from *Medical Record*, May 6, 1893.

*Apparent and Actual Mortality;* by F. D. BULLARD, M. D., Lecturer on Chemistry in the Medical Department of the University of Southern California. Reprint from *Southern California Practitioner*, June, 1893.

This pamphlet is devoted to a review of the mortality of various diseases in the southern part of California with a defence of the salubrity of that region.

*Thirteenth Annual Announcement of the University Medical College, of Kansas City;* (Formerly Medical Department University of Kansas City.) Nos. 911 to 913 East Tenth St., Kansas City, Mo.

*A Case of Mediastino-Pericarditis in a Child;* Secondary Empyema; Operation; Death; by WM. A. EDWARDS, M. D., San Diego, California; Associate Pathologist to the Philadelphia Hospital etc. Reprint from the *International Med. Magazine*, June, 1893.

*Practical Details in the Preparation of Plaster-of-Paris Bandages ;* by H. AUGUSTUS WILSON, M. D., Professor of General and Orthopedic Surgery in the Philadelphia Polyclinic; Clinical Professor of Orthopedic Surgery in the Jefferson Medical College. Reprint from the *Philadelphia Polyclinic*, Feb. and March, 1893.



## Medical Progress.

### THE ROLE OF THE POSTERIOR URETHRA IN CHRONIC URETHRITIS.

In a paper read by Dr. Bransford Lewis, of St. Louis, before the June meeting of the American Association of Genito Urinary Surgeons (*Medical Record*, June 29) the author presents some very radical and unorthodox views on the frequency of posterior urethritis and its influence in the production of chronic gonorrhœas.

In Dr. Lewis' opinion, the posterior infection should not be looked upon as a complication, but as a natural feature, occurring with such unfailing regularity that an observer, watching carefully and critically gonorrhœal cases, must see a great many of them before he would meet with a single one that remained free from the so-called complication throughout the disease. This conclusion, to which clinical investigation had led him, was supported, in recent writings, by the following statistics of authors who had been pursuing a similar study of late years. Lesser asserted that of fifty-three cases of primary gonorrhœa under his care, the posterior urethra escaped infection in only four cases, making the frequency of posterior urethritis 93.5 per cent. Jadassohn found posterior urethritis in 143 of 163 cases, making 87.7 per cent.; Rona found it in 79.7 per cent. of his cases; and Eraud found it in 80 per cent. of all of his cases.

In endeavoring to harmonize this undoubted fact of frequency of posterior urethritis with the reason for its frequency, the author disregarded, as in-

applicable, explanations usually given. Sexual intercourse, the "forced" injection, the passage of instruments, etc., during an active gonorrhœa, were chiefly complained of by writers on the subject,—extremely seldom by the patients themselves. Bearing on this point, the time and mode of onset of the posterior inflammation was of importance. Instead of the inflammation progressing slowly and gradually backwards over the urethral mucous membrane and reaching the posterior urethra in the second or third week, as was commonly taught, it reached the posterior urethra, in most cases, in the first (active) week of the disease. This rather favored the supposition of Horteloup that the mode of infection was through the lymphatics rather than by continuity over the mucous surface.

The author, therefore, felt justified in submitting the following conclusions:

1. The causes usually given for the prolongation of cases of clap (presence or absence of gonococci, stricture of large calibre, the use of particular drugs in treatment, etc.) do not satisfactorily explain them, nor do they furnish reliable means for prognosticating the outcome of a case.

2. A single widely prevalent cause for such prolongation of gonorrhœa has, as yet, not proved its right to recognition as such.

3. Posterior urethritis, by reason of its anatomical seclusion and inaccessibility to ordinarily-prescribed treatment, if frequent, offers the best explanation for such prolongation or repeated recurrence.

4. Scrutinizing clinical investigation shows posterior urethritis to be present

in the great majority of cases of prolonged or severe gonorrhœa.

5. Direct, topical treatment to the posterior urethra is, therefore, necessary in the great majority of cases.

6. The causes usually given for producing posterior urethritis are not commonly found to be real factors in the clinic.

7. The mode of onset usually described does not coincide with that discerned in clinical observations.

8. These two latter observations confirm the probability that the posterior urethral infection is accomplished through the lymphatics, and explain the frequency of such infection.

9. Posterior urethritis is not a complication, but a natural phenomenon of gonorrhœa.

#### ENUCLEATION OF UTERINE MYOMATA.

Writing in the *Amer. Jour. Obstet.*, August, Dr. A. Martin, of Berlin, says concerning this operation:

Finally, I have to add that enucleation preserves the possibility of conception. This consideration arises, at most, but in a limited number of cases. The majority have passed the boundary line; many are virgins; and in some the source of the sterility may be found in the husband.

In the remaining cases, however, the preservation of the sexual faculties is of inestimable value, as the observation of many cases has led me to conclude. That this desideratum was only fulfilled in a limited number of cases affords no legitimate objection; the mere possibility of an ensuing pregnancy has in many of my cases been sufficient to disperse

threatening shadows from marital happiness.

I am to-day able to report two cases in which conception occurred, labor proceeding spontaneously and without difficulty.

Now, if the prognosis of enucleation is comparable with the prognosis of the other methods, and the theoretical objections regarding recurrence are shown to be unjust, by what right dare we deprive these patients of the possibility of preserving their sexual functions?

These figures are sufficient to prove that this conservative operation adds no danger, so far as convalescence is concerned.

That the vast majority of patients are relieved of their symptoms and remain cured.

That recurrence or disease in the resected organs is exceptional.

That the woman preserves her sexual functions; and that pregnancy is possible with such partially preserved organs.

Practical experience has shown the objections to the conservative methods to be unwarranted. The criticisms must, therefore, be characterized as unjust. It may even be asked if this form of conservative procedure is not demanded under the conditions named, and if in these cases the operator has a right to destroy the female sexual functions.

#### WHY CANCER CAN HARDLY BE DUE TO A MICRO-ORGANISM.

Considerations which render this theory, now much in fashion, so improbable as to be well nigh impossible are as follows:

1. A parallel is supposed to exist between certain phenomena occurring mi-

croscopically in the cells and the coccidial disease which attacks the liver of rabbits. Clinical evidence negatives, however, any such theoretical analogy. The coccidial lesion of the rabbit's bile-ducts infests young rabbits, which may spontaneously recover; cancer attacks the elderly or old, very rarely the young, and no spontaneous cure ever happens.

2. Very conspicuous differences are found between every form of disease hitherto associated with a micro-organism, and cancer. Leprosy and tubercle always lay under strong suspicion of contagion for centuries before the discovery of the bacilli. Malarious fevers attack numerous persons exposed to similar conditions of soil and climate. Cancer bears no relation to soil or to any climatic condition whatever, although it is an appanage of civilization. It is non-contagious; for no large number of individuals suffer at the same time and in the same locality.

3. The consideration which goes furthest to negative the hypothesis of cancer causation by an extraneous micro-organism is the fact that the secondary metastases always involve a reproduction not merely of the particular cells concerned, but of their original arrangement and functional characters. The parent tissue in which the cancer process began is thus exactly mimicked by all the secondary deposits far and near. The familiar breast scirrhus, producing multiple nodules in the subcutaneous connective tissue, in each copies exactly the acinar structure of the mammary parenchyma. The metastases of a rectal cylindroma, frequent in the liver, reproduce the follicular composition of the primary lesion, developed from Lieberkühn's fol-

licles. Pigment-secreting cells in melanotic cancer continue to secrete melanine throughout all the very numerous visceral offshoots of that widely disseminated species. No known micro-organism can effect anything in the least resembling this. The bacilli of tubercle or leprosy stimulate to proliferation the cell elements of the tissues amidst which they arrive, but do not transport cells, which retain their functional endowments and original mode of distribution, bodily from one region to another.—Dr. Snow, *Lancet*.

#### CEREBRO-SPINAL FEVER IN LONACONING.

In the *Johns Hopkins Hospital Bulletin*, June-July, Drs. Flexner and Barker present an elaborate review of the course of the recent epidemic in this Western Maryland town. They describe it as follows:

The beginning of the outbreak was associated with a dance which had been given on a bitterly cold night, and at which two young men overheated themselves and subsequently became severely chilled; both developed the disease the next day. Later, numerous cases appeared in different regions at about the same time. Exposure to cold was a prominent predisposing factor, and a sudden cold snap was sure to be followed by the appearance of fresh cases.

The symptomatology presented, as usual, marked irregularities. Examples of nearly all types of the disease had been met with, *foudroyant*, acute, subacute, intermittent, and chronic. The young had been chiefly affected—one case having been observed in a child of five months. Young adults were often victims, and older individuals were by no



means immune, there having been several patients between the ages of 35 and 45. The onset was as a rule sudden, with severe pain in the head, and occasionally with rigor. There was often urgent thirst and projectile vomiting. The pain in the head was violent and almost intolerable, and passed on into delirium or stupor. Bright lights and loud sounds were painful; the eyes were prominent and watery and the conjunctivæ hyperæmic; cervical opisthotonos soon appeared, with general stiffness and hyperæsthesia of the body. Death sometimes resulted before the development of other symptoms, in one instance as early as five hours after the initial sign. In the less "explosive" cases the onset was usually sudden, too, but the progress was less rapid. Symptoms referable to involvement of the cranial nerves gradually appeared, and were of course most marked where there was evidence of extensive basal exudate. Among these were noted disturbances of sight, taste, smell, and hearing, eye-muscle paralyses, nystagmus—vertical and horizontal (in one case rotary)—disturbances of cardiac and respiratory rhythm, cyanosis, and defective speech. The ophthalmoscopic changes had already been carefully described by Dr. Randolph. The temperature course was characterized only by its great irregularity, and varied often quite independently of the general phenomena. Complications in the joints—peri-articular and intra-articular effusions—were relatively frequent; in no less than twenty per cent. of the severe cases were one or more joints affected. The knees, elbows, wrist and ankles were involved, following in frequency in the order named.

The cutaneous symptoms varied as much in character and duration as any of the others. In some instances no skin eruption of any kind was observed, while in others there were larger and smaller spots and mottlings of red and purple. Herpes was very common, especially in the distribution of the cutaneous vessels and nerves of the face and neck. On the part of the digestive system, vomiting and dysphagia were the main symptoms. Constipation was the rule, although in a few cases there had been diarrhœa, and in two well-marked dysenteric discharges.

The urine was usually scanty and concentrated, and contained in severe cases a trace of albumin, a few hyaline casts, and an excess of phosphates. Ehrlich's diazo-reaction could not be obtained in any of the specimens examined.

The majority of the cases occurred in the families of miners, but no class of people was exempt, nor were the more well-to-do much less likely to be attacked than the poor and destitute. The sanitary conditions in the valley were about as unhygienic as could be well imagined, and it seemed only strange that the epidemic diseases of various sorts had not played more havoc there. In Lonaconing, where most of the time had been spent, a river runs through the center of the town and acts as a main sewer for it. The houses in the town were for the most part built in rows, tier above tier upon the sides of the steep hills which rise from either bank of the creek. The outhouses belonging to the dwellings were placed flat upon the ground and usually upon a higher plane. During a thaw or rainstorm, the sewage and refuse from the upper yards, outhouses

and stables were washed down through the premises and past the dwellings of those who lived below. Upon the margin of the creek, in the very center of the town, were located the slaughter-houses, and refuse from these found its way unforbidden into the stream. The water supply of the place was derived chiefly from wells, and these were frequently contaminated with surface washings; besides, owing to their proximity to the creek, there seemed to be little doubt but that the well water had long been contaminated by percolation from the stream.

As to the distribution of the cases, it had been noted, as in certain other epidemics, that there was a tendency to grouping in little foci, chiefly in the elevated regions of the town; but there had been numerous examples of isolated cases. It was necessary to mention, too, that in many families overcrowding was evident.

#### UTERINE DRAINAGE FOR PYOSALPINX

Believing that judicious conservatism is the path of wisdom, if only it do not deviate toward undue timidity and lack of thoroughness, we observe with pleasure an article upon this subject in the *Amer. Jour. Obstet.*, August, in which, after relating illustrative cases from his practice, Dr. Murray says:

From an observation of these cases—and of the six cases narrated, three had been seen by eminent specialists, who had determined that nothing but operating could afford relief—and also from the practice of many specialists who curette the uterus, under antiseptic precautions, some time before celiotomy is done, with no bad results, even in pyosalpinx cases,

I believe the following conclusions are fairly deducible:

1. That many cases of pyosalpinx are curable without mutilating operations, if the endometritis be treated by curettage and drainage with strict antiseptic precautions.

2. That true drainage of a pyosalpinx into the uterus is possible and does occur when the tubes and ovaries are on a level with the uterus, and the uterine end of the Fallopian tube is patulous, or can be made so by treating the uterus.

3. That uterine curettage and drainage should be practised in every case before operation, unless the tubes are very distended and thin, to cure the endometritis; which may and often is a cause of trouble and lack of relief after celiotomy and removal of the organs is performed.

4. That, even after pyosalpinx, frequently the tubes and ovaries are not useless organs, the proof being that pregnancy occurs and the puerperium is normal.

5. That only after proper treatment the tubes, ovaries, and uterus remaining bound down by adhesions and a menace to life and health, should the radical operation be done.

6. As a matter of observation in large maternities, there are very few cases of puerperal complication due to the presence or results of a former pyosalpinx.

#### TWO FETUSES REMOVED BY ONE LAPAROTOMY.

Recently Dr. Byford presented to the Chicago Gynæcological Society specimens from a patient 42 years of age, showing the above conditions. In his remarks (*Amer. Jour. Obstet.*, August) he said:

Abdominal section February 21st,



1893, at the Woman's Hospital, assisted by Drs. J. T. Binkley and Marie White. Found the uterus and appendages matted together in a conglomerate mass the size of two large fists, with intestines adherent over them. Came first upon a hematosalpinx on right side, which burst and let out about four ounces of a bloody fluid. I then came down upon a membranous sac adherent in the pelvis, containing a fetus with bones well preserved. After tying off this side I found almost exactly the same thing on the left side, except that the tube contained a watery fluid. The adhesions were so firm that a portion of the cyst of the right ovary had to be left on an adherent loop of intestine, and the fetal sac of the right side had to be ligatured and a portion left on the rectum, to which it was adherent. No definite placenta was found. The operation was quite a bloody one throughout. Drainage for thirty six hours. Unusually smooth recovery, temperature remaining below 100° F. throughout, excepting a temporary rise during the second week from a superficial stitch-hole abscess in the unusually fat abdominal walls.

This is another of the many cases that are being discovered in which extra-uterine pregnancy has not killed the patient. It is the second patient I have had with two tubal pregnancies, none of which produced any apparent dangerous symptoms. The condition has by no means the mortality attached to it that many eminent surgeons would have us believe. I know of no other case in which both tubes, each with a fetus, have been removed at the same operation. The history, together with the mummified appearance of the fetuses, would make it quite probable that one of the conceptions occurred

seven years ago and the other five years ago; that each had caused a pelvic hemothecoele, had become encysted, and remained to trouble the patient ever since, but not to kill her.

#### HÆMATOMA OF VULVA.

In closing an article upon this subject (*Amer. Jour. Obstet.*, August) Dr. Murray says:

The most important question of all is the one in regard to treatment, and there are earnest advocates for both methods, the operative and the non-operative. It must doubtless be decided by circumstances. In deciding not to operate unless there should be some imperative demand for it, in the case presented, I had in mind a case of pelvic hemothecoele following labor which had occurred while I was interne at the New York Infirmity, in which the extravasation was rapidly absorbed without any interference. It was surprising how rapidly the mass in Douglas' cul-de-sac disappeared. It has been seen how rapidly this occurred in my case, and such is the history of most of those on record. The rapid changes, owing to the preparation of the parts for the subinvolution, must account for this. I say preparation, for several cases are cited where the hematoma occurred a week or two before delivery, and the healing was of surprising rapidity, whether left to absorption without incision and the emptying out of the clots, or after this was done. In either case great care should be taken to keep the parts aseptic, and the rule is that the patient goes on to recovery with little constitutional disturbance.

This brings us to the consideration of the gravity of the complication. Concerning this, too there has been great di-



versity of opinion. Girard thinks that it is considered more grave than it is, and that the number of fatal cases has been due to infection, wrong diagnosis, and the lack of skill of the ignorant midwives who have been in charge. He gives twenty-four cases in one hundred and twenty, Deneux gives twenty-two fatal cases out of sixty, Perret seventeen out of forty-three, Johnson and Sinclair two out of seven. The mortality depends upon the time that the hæmorrhage takes place and upon the extent of it. If it occurs during labor it is fatal both to the mother and the child. If it occurs late in the second stage, or after delivery, the prognosis depends on the extent of the hæmorrhage, but in the majority of cases has been favorable.

#### SUPPURATION IN THE ETHMOIDAL CELLS.

The ethmoidal cells are of great interest to the medical student in the days when he is preparing for examination in osteology; but after he has entered upon practice he hears nothing of them, although he wonders sometimes whether they are not subject to disease, like other cavities of the body. It is with interest therefore that we find in the journals an occasional case-report, like that of Dr. Stewart, who gives (*Lancet*) the following record of a patient under his care:

A married woman was sent to me at the Great Northern Central Hospital by my colleague, Mr. Morton, in the beginning of 1891. She told the following story. Twenty years ago she contracted scarlet fever. When convalescing, a large abscess formed in the corner of the right eye, and she also experienced slight deafness. The abscess in the eye burst without surgical aid, and both ears dis-

charged incessantly for a week and have done so from time to time ever since. She experienced no further trouble from the eye for ten years, but suffered occasionally from very severe headaches. When out one day she suddenly felt a most violent pain, which lasted for a week, and during that time she could not sleep or lie down and was at times unconscious. She consulted an oculist, who told her that she had a tumor at the back of the eye. He incised a hard substance in the corner of the eye, when a large quantity of pus came away. Eighteen months afterwards the eye was again very painful and the swelling was once more opened, but with little relief. The pain in the head was severe for some time; the swelling was opened again. Since then, nine years ago, the pain in the head from time to time had been almost unbearable, lasting from a few hours to two or three days. The swelling of the forehead and temple was always much inflamed whilst the pain lasted. Five years ago, after a very bad attack of pain, the patient used a strong lotion, as hot as possible; this brought away quantities of pus down the nose into the throat. Large masses had since come down into the throat. During the last few months the swelling in the corner of the eye had become larger. The eye itself was more prominent, the attacks of pain were more frequent, and affected the teeth so much at times that she could not bite anything. The parts seemed numb when not painful.

When I saw the patient two years ago the right eye was pushed outwards and downwards, protruding to a considerable extent, and there was a round swelling in the interior and superior corner of the orbit. The canaliculi had been slit up and there was some discharge oozing

from them. On examining the nose a large swelling occupied the place of the right middle turbinate bone which to the probe felt hard and tense. The nasopharynx was free. Under an anæsthetic I punctured the turbinate enlargement with a trocar and on inserting my little finger into the nostril the tumor crackled up before it and I was enabled to pass the finger on into the orbit. I therefore made a free incision into the internal and superior corner of the orbit and found a large amount of dead bone and the orbit full of stringy pus which was pushing out the eyeball; the pus had also hollowed out a cavity in the direction of the frontal sinus into which I could insert the tip of my little finger. All dead bone was removed and the orbit washed out for a quarter of an hour with a warm boric acid solution until the pus and débris had been entirely cleared out. A large drainage-tube was then inserted into the nostril and brought out through the wound at the corner of the orbit. The patient did remarkably well, and now, two years after the operation, the nose remains free. The eye has gone quite back to the middle line, though it has not quite recovered its proper level. There is slight hyperæsthesia round the orbit. The patient was seen by the late Sir W. Bowman with Mr. Morton before she came under my care, and he pronounced it a case of suppuration in the posterior ethmoidal cells. The case was shown at the February meeting of the North London Medico-Chirurgical Society.

#### CORNET PLAYER'S CRAMP.

The following unique case is reported by Dr. Turner in the *Lancet*:

The list of occupation-neuroses (Beschäftigungs-Neurosen) does not include, so far as I can ascertain, an instance of the condition illustrated by the following case, nor is the patient himself aware of the occurrence of a like affection amongst his professional brethren:—A man aged twenty-nine has played the cornet as a means of livelihood since he was nine years of age. For ten years he was in the band of the Coldstream Guards, but for the last few years he has devoted himself to orchestra and solo playing. About two years ago he noticed that he was unable to sound certain notes, from an inability to direct the movements of his tongue for that purpose. This condition has remained more or less constant until the present time. The patient gives a highly intelligent account of his condition, which is as follows: He is unable to make certain movements of the tongue which are essential for the acts known as "single, double and triple tonguing," and which may be graphically represented by the signs tu;" "tu ku;" "tu tu ku" respectively. This movement is readily imitated by imagining a hair on the tip of the tongue which one is endeavoring to remove by inserting the point of the tongue between the lips and blowing. An interesting feature in connection with the case is that he can perform these movements readily and easily in his own room when practising or when allowed his own time, but he cannot do so when suddenly called upon by the conductor's bâton. He has also noticed that after playing for some time the condition of his tongue improves instead of becoming worse. In all other actions, both in playing the cornet and otherwise,

the movements of the tongue are perfectly good. At no time was there any pain in it. Physical examination showed that the tongue was large, atonic and somewhat indented at the margin by the teeth, but this condition improved very much under the influence of strychnia and dilute hydrochloric acid. There were a few fibrillary tremors towards the point. The tongue reacted normally to galvanism and faradism. There was no affection of the lips or soft palate, and the linguals and labials were well formed. Both knee-jerks were equal and of normal force. The patient has always had good health; he is a non-smoker and temperate. There is no known history of any neurosis in the family. He is unable to ascribe any exciting cause for the affection except that at its outset he was in feeble health after a somewhat severe attack of influenza and was at the same time busily engaged in his professional work.

The only movements of the tongue which are implicated in this case are those essential for the production of certain (staccato) notes upon the cornet, hunting-horn, or other wind instrument; these movements have been acquired, and they are the most complex which the players upon wind instruments require to produce. In other words, certain cell-groups subserving the movements of the tongue have been educated by practise for the perfecting of certain actions, all the other more natural movements of the tongue being unimpaired. It has been pointed out that if in the occupation-neuroses the affected movements are fine (*e. g.*, in writers, pianists, telegraphists, &c.) these special movements only are implicated,

whilst if the movements are coarse (as in hammermen, treadlers, &c.) other actions than that of the occupation are impaired. For example, the patient suffering from writer's cramp can, as a rule, readily work the typewriter or play the piano, or, as Dr. Poore has shown, even write with a pencil; but the sufferer from treadler's cramp has great difficulty in going upstairs. The probable explanation of this is to be found in the fact that the fine movements required in writing, piano-playing, &c., are complex and special movements only acquired by education and practice, whilst the coarse movements of the hammerman and the treadler, although used by them in an exaggerated and altogether abnormal way, are those which are normally and daily performed in the ordinary habits of life. Hence one has to look for the cause of the occupation-cramps in fatigue, nutritive impairment, or even temporary paralysis of cell groups; either those which, having been specially educated for a particular action, are thereby more prone to fatigue, or those which, regulating certain normal movements, have been worked to excess.

#### THE LAWS OF HEALTH.

The true secret of health and long life lies in very simple things.

Don't worry.

Don't hurry. "Too swift arrives as tardy as too slow."

"Simplify! Simplify! Simplify!"

Don't overeat. Don't starve. "Let your moderation be known to all men."

Court the fresh air day and night. "O, if you knew what was in the air!"

Sleep and rest abundantly. Sleep is nature's benediction.



Spend less nervous energy each day than you make.

Be cheerful. "A light heart lives long."

"Work like a man; but don't be worked to death."

Avoid passion and excitement. A moment's anger may be fatal.

Associate with healthy people. Health is contagious as well as disease.

Don't carry the whole world on your shoulders, far less the universe. Trust the Eternal.

Never despair. "Lost hope is a fatal disease."—*Chicago Medical Times*.

#### OZONE.

Commenting on a new method of producing this allotropic form of oxygen, a recent number of the *Lancet* says:

Even were ozone to be produced in a tolerable state of purity we cannot see how it would become available for the many purposes for which it is supposed to be so valuable, besides which, there is the question of its storage. Ozone, under ordinary conditions, is a gas which is probably more difficult to preserve than any other known gas. Apart from its tendency under the slightest provocation to "explode back" into ordinary oxygen, its extraordinary power of diffusing through many substances is a difficulty that must be reckoned with. As an illustration of this property may be mentioned the fact that it passes through comparatively stout rubber tubing as though it were wire gauze. Then, again, ozone in quantity is decidedly poisonous, whilst its presence in the air to any extent produces irritation of the mucous membrane. Ozonisers for the production of ozone in a room may perhaps be used with advantage for

disinfecting purposes, for it cannot be disputed that it is a powerful oxidising body although, oddly enough, under some conditions it may actually effect a reducing action. The normal presence of ozone in the air is still a disputed point, for the simple reason that the tests which have been looked upon as sure indications of its existence are known to respond to other things which occasionally occur in the atmosphere. Such are, for example, nitrous acid, chlorine, and perhaps peroxide of hydrogen. Ozone has been employed, it is also stated, for the rapid production of mellow spirits and especially of whiskey; but it is not unreasonable to expect that, if oxidation of the raw products and the higher alcohols of spirits is easily accomplished by this means, oxidation of ordinary alcohol to acetic acid would also ensue. If this were the case the flavor that is characteristic of a normal mellowed spirit would be materially and unfavorably affected.

#### HEART FAILURE.

The following statements of a high authority seem to us worthy of quotation even at second hand from the *Columbus Medical Journal* and originally from the *Medical Age*:

Prof. Alfred L. Loomis read recently before the American Climatological Association a paper on Heart Failure.

He includes all heart failure in three classes:

1. Those in which the heart has for a long time been called upon to perform an abnormal amount of work, as in valvular or arterial disease.

2. Those in which obstructive changes in the coronary vessels markedly dimin-

ish the nutritive supply of the cardiac muscle.

3. Those in which toxic influences act directly upon the nutrition of the muscle, or so interfere with the cardiac nerve supply as to lessen cardiac resistance.

He concludes with this excellent advice, in his summary of his conclusions, as to the lessons taught by the facts demonstrated. He says:

"However we may explain it, clinical observation teaches that some chronic and many acute infections so diminish heart power that sudden heart failure occurs in hearts that previous to this infection were of normal integrity. It then becomes of the utmost importance, in all toxic conditions, to watch for the first indications of cardiac weakness. On this principle Stokes based his great rule for the use of alcoholic stimulants in the treatment of typhoid fever, when he directed, 'that in every case of fever, if the first sound of the heart became indistinct, stimulants should immediately be given in sufficient quantities to restore the heart tone.' It is on this principle, also, that strychnia upholds an alcoholic heart in pneumonia, by restoring or increasing its nerve supply. A rule which for a long time has governed me in all toxic conditions is, not to wait for signs of commencing heart failure, but to begin the administration of alcohol, strychnia, and other heart tonics early, and thus, if possible, save my patients from fatal heart-failure.

"A review of the cases which I have presented makes it evident that the term heart-failure is misleading and should be abandoned, for, in most instances, it does not express the pathological state.

It is equally evident that the term 'death from heart-failure' is often used to cover the ignorance of the medical attendants."

### Medical Items.

Notwithstanding the prevailing financial depression, the classes in our city medical schools are very encouraging.

Dr. N. L. Dashiell, Jr., has taken the office of Dr. Wm. H. Clendinen, N. E. corner of Broadway and Fayette St., and has full charge of his practice.

A good many physicians now recommend "cycling." They should do it with caution; and the manufacturers would do well if they would invent a "health bicycle" which could only be propelled by a person who sits erect.  
—*Ex.*

The authorities at Dieppe have recently issued their annual instructions to the life savers who patrol the bathing beach during the season. Among other rules is one instructing them "when a lady is in danger of drowning to seize her by the dress, and not by the hair, which oftentimes remains in their grasp."  
—*Gaillard's Med. Jour.*

The next session of the French Surgical Congress will be held in Paris the week commencing on the third Monday in October, 1894, the questions to be discussed being the Etiology and Pathogenesis of Cancer and the Surgery of the Spinal Column. The new President is Professor Tillaux and the vice-chair will be occupied by M. Alphonse Guérin,

Negro graves in the south are often seriously garnished with the bottles of medicines used by the departed in their final illness, and the duration of the malady is easily guessed by the number of bottles. Often these are the only things to mark the mound.—*Med. Press.*

It is significant to find an authority of the high standing of the latest Fothergillian medalist declaring his growing belief in the efficacy of drugs in the treatment of disease. We cannot do better than quote some of his own words: "I have been surprised," he says, "at the amount of good that has been done in affections commonly looked upon as intractable—relief, arrest and restoration. With each successive year's experience it seems to me greater and more distinct and to elicit more gratitude from the patients to whom it is applied." These words are very encouraging, and we have no doubt that during the next few years there will be discovered even more potency in the weapons already at our disposal, as most certainly new ones will be revealed.—Editor of the *Lancet*.

The sixteenth annual reunion of the Union Medical Association, composed of Pennsylvania and Maryland physicians, was held August 21, at Chickies Rock, near Columbia, Pa. Dr. John Morris, of Baltimore, presided, making an address complimentary to the citizens of Columbia. No reference in the addresses was made to the medical profession except in a jocular sense. The other speakers were: Dr. H. G. McCormick, of Williamsport, Pa.; Dr. John K. Lineweaver, of Columbia; Dr. Pottager, surgeon of the Fourth Regiment Pennsylvania

State Militia; Dr. J. L. Zeigler, of Mt. Joy, Pa.; Dr. J. B. Roberts, Philadelphia; Major W. Hayes Grier, of Columbia; and Dr. Hobart A. Hare, of Philadelphia.

About one hundred physicians were in attendance.

Dr. Levi Frey, of York, Pa., was elected president for the ensuing year, Dr. R. E. Bromwell, of Port Deposit, Md., was placed on the executive committee.

The next annual meeting will be held at Chickies Rock.

At a special meeting of the Alumni Association of the College of Physicians and Surgeons, held at the college building September 1st, 1893, at 8 P. M., the following preamble and resolutions were unanimously adopted:

Whereas the Alumni Association has heard with profound regret of the death of Dr. John W. Branham, Assistant Surgeon of the United States Marine Hospital Service, while in active service at Brunswick, Ga.

*Therefore, be it resolved*, that in the death of Dr. Branham the Association has lost a member of high attainments and great promise of a brilliant future; that we hereby express our admiration for his bravery in the performance of his duty of protecting his country from the inroads of disease.

*Resolved*, that we hereby tender our heartfelt sympathy to his bereaved family.

*Resolved*, that these resolutions be spread upon the minutes of this Association, that they be published in the daily papers and that a copy be sent to the family of the deceased. Signed, Wm. F. Smith, C. Hampson Jones and Wm. J. Todd, Committee.



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### Original Articles.

#### ACUTE INFECTIOUS PERIOSTITIS WITH THE REPORT OF TWO CASES.\*

BY FRANK C. BRESSLER, M. D.,  
OF BALTIMORE.

Of all pathological processes attacking bone and its component parts, none will be followed by such excellent results if properly diagnosed and treated as the acute infectious inflammations of bone and its coverings, *i. e.*, osteo-myelitis and periostitis.

One of the greatest calamities that may happen to one so unfortunate as to suffer with the above diseases consists in the failure of the attendant to recognize them promptly and early; by this

failure untold misery may follow, from a possible cortical necrosis to loss of life. The subject becomes one of prime importance and always demands that the medical man be on the alert, as the failure to recognize it frequently stamps want of surgical acumen and care. Hence, if in doubt, it is better to cut, aseptically, than to sacrifice life by conservatism and regrets afterwards of hindsight.

Definition.—Acute infectious periostitis consists of a localized inflammation beginning usually in the deeper layers of the periosteum, rapidly involving the underlying bone, osteo-periostitis.

Development.—Its development may be very rapid; all, no doubt, depending upon the violence and quantity of germs present. In the beginning, as a rule, it starts from the diaphyseal extremity of

\*Read before the Medical and Chirurgical Society of Baltimore.

the long bone. Happily, the epiphysis is rarely involved, owing to the cartilaginous layer between the diaphysis and epiphysis limiting the inflammation. Owing to the periosteum being attached to this cartilaginous layer, the pus, as soon as formed, begins to travel along between shaft and periosteum; the latter not being firmly attached, offers but little resistance to its progress. It thus may dissect up the entire membrane; and if relief is not quickly given the whole membrane will become separated, with possible serious result to the future of the shaft. Hence the all-importance of recognizing the trouble at its incipency.

Joints escape.—Fortunately, the joints rarely participate in this trouble owing to the above-mentioned attachment of the periosteum to the cartilaginous disc; to this there is one exception, and that is the upper portion of the femur; here the capsule is attached below the cartilaginous layer; still the joint may escape, as in a case reported by Dr. Owen, in which acute periostitis of the upper portion of the femur took place, the case being diagnosed and promptly treated, got well without hip-joint being involved, but convalescence was delayed by pyæmic abscesses.

Age.—No age is exempted. It is, however, a disease chiefly of early life.

Seats.—Tibiæ, femora, next bones of the upper extremities.

Causes.—All diseases that reduce the vitality of the system tend to its development. It is also very prone to follow, under the slightest provocation, after the infectious diseases, such as typhoid, variola, measles, scarlatina and

so on. Hence we must be on our guard in the various infectious fevers, if suspicious pain, rise of temperature, localized pain and redness appear near the epidiaphyseal junctions.

Trauma is the chief factor to its active development, and by the resulting tissue changes a favorable nidus is formed for the pyogenic germs which induce the various destructive changes in proportion to the length of time and class of germs present. Strange to say, the trauma may be so insignificant when received as to escape the patient's observation.

Germs.—It is agreed by surgical pathologists that there is no particular germ which provokes this special inflammation, but it is settled that the staphylococci are the chief agents leading to its development, the staphylococcus pyogenes aureus being the predominating one.

Next to the staphylococci, it is claimed the streptococci can induce this disease. Again it may be a mixed infection, *i. e.*, staphylococci and streptococci.

Pathology.—The inflammatory changes are the same as those of all phlegmons, modified, of course, by the resisting bone structure or tough membrane. It is extremely rare for acute periostitis to be unassociated with some osteo-myelitis; in fact, some surgeons classify it as a mild type of acute infective osteo-myelitis. Hence the pathological changes will depend both upon the length of time and severity of the inflammation.

Symptoms.—Shiverings, headache, vomiting, diarrhœa, drowsiness, delirium, convulsions, rigors, high temperature, which may reach 106°; some cases, however, may last several days, destroying to a marked

extent bone, even causing death without decided temperature. Cases of this character frequently escape recognition owing to the predominance of the resulting secondary symptoms due to complications. Symptoms of this last mentioned type strongly simulate meningitis, cerebral pneumonia, typhoid fever, ulcerative endocarditis, etc., thus obscuring the primary disease by such as simulate the above; and unless the medical man is on the alert, his case dies simply for want of discovering the original trouble. It might then be a good rule to press upon the epidiaphyseal junctions of the long bones in children, who may be suffering with obscure fevers of unknown origin.

If the bone is superficial, such as the crest of the tibia, lower ends of femur or fibula, and if the skin covering the bones becomes reddened, rapidly passing into a brownish hue, associated with localized pain of a severe character, the trouble is clear and easy of diagnosis; but if placed deeply and covered by numerous layers of tissue, the diagnosis is frequently difficult, since the constitutional symptoms may simulate other disease before any external symptoms may show themselves. The most noticeable features of my cases were rapid constitutional depression, plus deep constant pain.

Prognosis.—The prognosis depends upon the patient's vitality and early recognition of the disease. If properly treated the result is usually favorable; but if not diagnosed the case becomes grave from secondary complications, namely, septic pneumonia, pyemia, meningitis, septic endocarditis, etc. Should the process remain undiscovered until the entire periosteum is separated, it is worthy of note that the shaft does not neces-

sarily necrose; since the blood supply is derived from two sources, nutrient and periosteal, hence the nutrient would maintain the necessary nourishment; should, however, the periosteum be separated and the nutrient vessels be blocked, total necrosis is strongly probable; even under such circumstances the periosteum sometimes has sufficient osteo-genetic properties left to reform bone.

Differential diagnosis.—The disease most likely, and by far the most mistaken for it, is acute rheumatism. In both of my cases acute rheumatism had been diagnosed and the cases placed upon rheumatic treatment. I believe it ought to be a uniform rule in treating children with rheumatic symptoms to bear in mind that the trouble under consideration simulates and must be excluded before we settle definitely upon its being rheumatism.

Rheumatism.—In rheumatism we have several joints involved. Fever high and face is expressive of suffering with pain. Pain not localized to one definite spot, but more general and around the joint. Edema and redness not localized, but surrounds joint. Edema of not so plastic character. Redness of a more erythematous hue and devoid of that dark red, shading into a bluish tint. Pain not boring, and relieved by absolute rest to joint movement.

Erysipelas.—Erysipelas may at times simulate it at first but we have here the distinct border line. Redness spreading rapidly in all directions. Redness uniform over involved area. Pain not limited definitely to one spot and radiating therefrom.

Sprain.—Absence of fever. History of a definite injury (twist) to joint, swell-



ing localized to joint proper. Epidiaphyseal junction not the most painful spot, but pain confined to and around joint. Constitutional involvement absent.

Central osteo-myelitis.—Central osteo-myelitis is difficult to diagnose from, but here at first we have absence of local pain when skin is pressed upon. Œdema at first absent. Redness, at first, likewise absent. Constitutional symptoms are profound and rapid. It is septic in character. Pain is deep and severe.

The symptoms, as a whole, very pronounced and before any external sign may show itself patient may be in a typhoid condition.

Deep pressure, however, even though the patient be unconscious, will cause him to wince later on. In those cases simulating typhoid fever, malarial fever, meningitis, etc., by a careful search and systematically pressing the epidiaphyseal junction the diagnosis can be cleared up, since if the patient suffers from the trouble under consideration, these points will be sensitive and he will flinch when they are pressed upon.

Treatment.—Treat antiseptically by a clean and free incision in the direction of the long axis of the bone; if one of the flat ones, cut as is proper for the involved bone. If you have struck the trouble and cut properly, the patient's pain will stop, temperature drop, and constitutional symptoms rapidly change for the better. If, however, the temperature remains up after above treatment and the constitutional symptoms get worse, it means a complication. Examine now the lungs, kidneys, heart and joints; if these seem to be free from trouble, suspect central osteo-myelitis; trephine sus-

pected bone in several places if necessary and drain properly if pus is found.

If shaft has been entirely dissected and lies loose in pus, lift it out gently and apply extension moderately until cavity refills; treat cavity as any other wound of a similar nature. Try bone grafts.

In addition, constitutional treatment is necessary, such as benefits diseases of like grave character. Change dressings only when necessary, being guided by patient's symptoms and condition.

In conclusion, I append the histories of two cases.

Aldert D., aged 8, white. Previous health good. Was asked to see him Saturday evening, December 31, 1892, for a supposed case of acute rheumatism of the ankle joint. His history was as follows:

Last Tuesday had several attacks of momentary pains around ankle joint. These pains were attributed to the cold and his having been out sleighing all afternoon, plus the over-exertion of hill-climbing. No complaint was made the following day. On Thursday, however, he again complained of some pain, still it did not keep him in the house. That evening his mother rubbed his ankle joint with Stokes' liniment, but observed nothing abnormal while so doing it. On Friday was out all day with his sled, towards evening seemed a little feverish, complained of the pain being more severe than heretofore. His mother stated that the joint seemed slightly swollen and a trifle red. She rubbed it with a powerful horse liniment. That night the little fellow suffered considerably, seemed feverish, restless and slept poorly. On Saturday morning patient seemed worse, ankle was very much swollen, looked

very red and irritated and he complained of great suffering. Seemed very feverish, looked pale and careworn.

His condition grew rapidly worse, so that I was sent for. I saw him about 5 P. M. Found the boy very feverish, complaining of constant pain in the ankle, but easier just now. Ankle swollen chiefly on the outer side of the leg. Skin inflamed, having an angry color as if cellular erysipelas was present. On passing my finger along the lower part of the fibula, about one inch above joint, find a localized spot exceedingly painful to the touch. Pain decreasing as finger moves away from this spot. No evidence of pus can be gotten. Patient says he has no boring pain but more as if something was moving about in the skin; no history of an injury could be gotten; bowels open, appetite lost. Says, "He feels very bad." Was peevish, nervous, looks very sick, as if suffering with sepsis. All other joints normal. No previous history of rheumatism, syphilis or scrofula. I came to the conclusion that my patient was suffering with acute infectious osteo-myelitis; I advised immediate operation, stating the grave results that may follow in case of delay. The father not being home, the mother refused to give her consent. Late that night, the father saw me and consented to my operating. On Sunday morning our patient was gotten ready and under antiseptic precautions a clean, deep incision was made down on to the fibula over its lower fourth. As soon as the sensitive point was struck, a small quantity of dark green pus came into view, possibly a good teaspoonful, the pus lying between bone and periosteum in the proximity of epiphyseal junction. I then began,

however, to dissect up the periosteum for two inches towards the upper portion of the bone. The bone was roughened and intensely inflamed. The tissues cut through were deeply congested and infiltrated with serum. The incision was enlarged until healthy bone was gotten. The wound thoroughly irrigated, bone carefully examined and found to be free from deeper involvement. Wound cavity packed with iodoform gauze and dressed as usual.

I might say the patient's condition before operation had become very bad, having been very feverish all night; temperature  $101^{\circ}$  at present. This low temperature, no doubt, was due to phenacetine in  $3\frac{1}{2}$  grain doses every two hours, as his condition indicated that the temperature would have been much higher had not this antipyretic been given so constantly. Looked haggard and careworn as if he had been sick for weeks. Complained of severe pain on the outer side of the ankle joint. Pulse quick and soft; occasionally delirious, jumps and starts up in his sleep, limb looked very much inflamed and dusky. Ankle joint swollen chiefly on its outer sides.

The wound was dressed the following day and looked very much improved. The patient's condition, likewise, had made a wonderful change for the better. The case remained under my care for two weeks and was then discharged cured. Four months later, find the patient in excellent condition, limb entirely well, never having had the slightest trouble since he was discharged.

Leo Jackson, age five, white. Previous health good. Was perfectly well Saturday, August 27, 1892, having

jumped and played as usual. His mother put him to bed apparently perfectly well, but woke up toward morning with pain in his left ankle; was cross and seemed to be feverish. All that day seemed to make few efforts at walking, saying that his foot hurt him. Looked badly, fever kept up, lost his appetite, seemed sore all over and lay down nearly all day. His mother gave him various house remedies but with no decided benefit. Sunday night his condition seemed worse, occasional delirium, very feverish, pulse quick, could not sleep and kept tossing from one side of the bed to the other. When asked what ailed him, said his foot hurt. Ankle seemed puffy, a little red towards its outer side. Early Monday morning the family physician saw him, who pronounced the patient as suffering with typho-malarial fever and a sprained ankle. On Tuesday the patient seemed worse. Owing to the doctor being called out of the city, another one saw the boy on Wednesday, who pronounced the case one of erysipelas. Prescribed for it, but the patient seemed to get worse and pain in ankle unbearable. The patient's condition grew likewise serious. Fortunately on Thursday the pus made an exit through the skin, with relief to all symptoms. The quantity was small, possibly half an ounce. Shortly after I saw the case the patient was relieved from his urgent symptoms, but complained of some chills, plus a very severe pain in his right hip-joint. The wound over fibula was discharging small quantities of pus; some pain, particularly if the foot was used; looks pale, anæmic, appetite poor, perspires freely, pulse rapid and soft. Suspecting that the hip-joint might mean pyæ-

mia, I had the boy anæsthetized, and an incision was made of the fibula over its entire length. Found that the purulent collection had been chiefly located over the epidiaphyseal junction, between the bone and periosteum. The periosteum was firmly attached to the lower epiphysis but had been separated from the diaphysis, its entire outer surface. In addition, the fibula had participated in the inflammation, giving rise to a thin cortical sequestrum which was easily removed. The bone was thoroughly curetted and all pockets and suspicious tissues removed; wound was irrigated, packed with iodoform gauze, brought together with stitches except angles for drainage, dressed in the usual manner. The wound healed well except lower angle; and outside of some little proud flesh a perfect result was ultimately gotten. Now six months since the case was discharged, patient is perfectly well and the limb sound.

From the histories, these two cases are extremely interesting and unique, since in both cases the inflammation attacked the lower extremities of bones which are seldom involved. Again, contrary to the general rule, the lower extremities were affected, those supplied by the nutrient artery; whereas those extremities are generally selected distant from the nutrient blood supply.

Another interesting point is that both lower left fibulæ were involved with histories identical. Still another point is the paucity of cases recording primary attacks of acute infectious osteomyelitis of fibula.

Lastly, the first case was promptly recognized and treated properly, thus avoiding damage to tissue involved as



well as to the patient's constitution, resulting in a speedy recovery; on the other hand, the second case was wrongly diagnosed at first, hence considerable destruction of involved tissues resulted, with the danger of a possible pyæmia complicating the case at one time, plus a prolonged lowering of the patient's constitutional powers, requiring weeks to build up, and lastly necessitating for recovery a prolonged and extensive operation. All of which could have been avoided by a little care in making the diagnosis by simply making pressure over the involved area, following it up by the proper incision down upon the bone.

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## DISPUTED POINTS IN HYSTERECTOMY.\*

BY JOSEPH PRICE, M. D.

The mooted questions in surgery grow less as our experiences enlarge and ripen. There are in our science and art some certainties, some points upon which there is unanimity of enlightened opinion. There are, however, also, as in all other sciences and arts, as in all other lines of human enterprise and endeavor, disputed points; disputed, we must take it, from the standpoint of conscientious opinion. These differences are the chief factors, the motor forces of our advances. Without them inertia would take the place of our activities. The fact of our advances is not disputed; the lines along which they have been made direct the way of interesting and instructive study. We have a profound interest in the names

and work of those toiling pioneers who have blazed the trees for our guidance to lessen the difficulties of our following. What they have done for womankind will always lie beyond the power of biographical pen to narrate. We would find it difficult to distribute our debt of obligation when we come to consider the great labors, the brilliant work of McDowell, Kimball, and the Atlees, of Pean, Keith, Koeberle, Hegar, Billroth, Kalténbach, Kleeberg, Schroeder, Lawson Tait, Bantock, Thornton and many others. We find stimulus in such names and such records for worthy following. They have given us the sublime lessons of their experience. What masters they are—all of them! They represent the genius of science, of practical skill; they have enlarged our resources; they have helped us to make many lives worth living. Some of these men are living today, are yet giants at the wheels, yet students in the solution of great surgical problems.

In considering the definitions of hysterectomy we must bear in mind nomenclature. Schroeder's term, myomotomy, is not synonymous with hysterectomy; is not hysterectomy; it more appropriately applies to simple extirpation of the tumor. Hysterectomy is the removal (Kimball's operation) of the whole body, or any section of the uterus, with tumors inseparable therefrom. Such high authority as Thornton places within its field all cases in which the uterine cavity is laid open and more or less of its wall removed along with the fibroid; whether one or both ovaries is also removed is a matter of no consequence. Sometimes it is more convenient to remove one or both, applying the term vaginal hyste-

\* Read before the Philadelphia County Medical Society.

rectomy to cases in which fibroids, the uterus, and the uterine appendages are all removed.

The progress made in perfecting the operation has taken some disputed points out of the field. Experience has given something of definiteness to our views; still there are two camps. The disputed points involve methods, rather than question of the justifiability or safety of the operation; on these points there is unanimity of sentiment among experienced surgeons. There may yet be some division of opinion as to what cases should be operated on, and what cases should be let alone. The operation was long regarded as one of the most fatal in surgery. The low rate to which the mortality following the operation has been reduced, where the cases fall into experienced and skilful hands, has given to it an abiding and important place among the life-saving procedures. In the matter of methods, men are likely to credit those methods with being best which, by their own tests and in their own individual and professional experience, have given the best results. One or more failures with any one particular method of procedure drives some men to try others. With their first success they christen the baby "My method," "My modification," "My improvement," or "My invention," and the entire profession is exceedingly glad that a new genius has been born into the profession—that there is a new light in Israel.

The history of the treatment of the pedicle in ovariectomy has influenced all of the older ovariectomists to try the same methods and materials to perfect an intra-peritoneal method in hysterectomy. The early ef-

forts of Schroeder were quite successful. Some of the younger operators have improved the statistics by clean extirpation, but we yet remain in two camps as to the management of the pedicle.

Operators clinging to the nœud and the extra-peritoneal method are making the best showing, operating right along with a very low mortality. It cannot be inferred from the success of the intra-peritoneal method in ovariectomy that improved or equally successful results will be attainable by the intra-peritoneal method in supra-vaginal hysterectomy. The results in many large and ripe experiences establish the fallacy of this idea; such inference is in blind disregard of essentially different conditions. Ligatures cannot be safely used in uterine, fibroid, or myomatous tissue. Silk, as applied to the pedicle in cystomas, is harmless and safe.

I would say here that the earlier errors in diagnosis, mistaking cystiform degeneration, fibroids, or œdematous myomas, for ovarian cystoma were common, and the cases were either abandoned, or incomplete operations done with disastrous results. Some of the most skilful operators did not escape making these errors.

The treatment of the pedicle has been repeatedly and exhaustively discussed. Results have dampened the enthusiasm of the advocates of the intra-peritoneal method.

It is necessary in the removal of about all fibroids to make a pedicle. Its manufacture in extra-peritoneal hysterectomy is the one important feature of the operation. It should be made small. Suturing securely against hæmorrhage is also the important feature in the intra-

peritoneal, and the avoidance of hæmorrhage and the ureters are the important features in the extirpation method.

Shock is minimized in the extra-peritoneal method, the operation being shorter, exposure and manipulation less, than in any of the intra-peritoneal methods.

The method of turning the pedicle into the vagina is a tedious operation; the risks of hæmorrhage and of injury to the ureters is even greater than that of a clean extirpation of the cervix.

The question is often asked, "Why leave the cervix or stump in at all? it is the most common source of hæmorrhage and sepsis in all the intra-peritoneal methods." Its removal is the perfected operation, but the results as yet have not been as good as in the extra-peritoneal method of treating the stump.

Hæmorrhage is incident to the supra-vaginal, as it is to all the methods. The bleeding varies greatly, and sometimes is absent altogether. In this procedure the elastic ligature (Kleeberg's) and wire ligature minimize the risk of hæmorrhage. The chief danger in the intra-peritoneal method is bleeding from the pedicle. Drainage, or the dry treatment, where adhesions have been extensive, is of vital importance in these operations. It is an important object to get and keep the stump dry. In some cases you need not change the dressings for a week or more. They should be changed when they become moist. The advantage should be kept in mind of sewing the edges of the peritoneum across the stump, thus preventing retraction when the loop has become somewhat loose from the shrinkage of tissue. The duration of the operation is one of the many factors to be considered. There should be that rapidity

consistent with due caution and scrupulous attention to essentials. There is no time for fussiness. There is the shock of the anæsthetic. Extensive adhesions, bowel and bladder complications, require painstaking surgery; and tedious and slow the steps of the procedure, and somewhat lengthy, however deft and educated the hands engaged. Temperature is an important consideration. Supplying dry heat throughout the operation will avoid, to a very great extent, the shock due to the chill of the atmosphere. In the matter of shock, long exposure and long anæsthesia count for much. It should be kept in mind, however, that to deal with an abdominal wound carelessly or too hurriedly is bad surgery. Every step should be timed to the needs of the case, every motion that of a master workman, and there should be summoned into service every resource of our science and art.

When we consider hysterectomy in all its phases, the condition of the patients when they come into our hands, the dire extremity that drives them to us, that they come to us with general health broken down, often complete physical wrecks, and familiar as we are with resultant issues—we have no difficulty in appreciating the difficulties we have to encounter. The professional responsibility is a heavy one. The patient's condition suggests the urgent question: "What should be done?"

We appreciate the truth of J. Knowsley Thornton's statements; we accept them in the main as surgical truths, into the acceptance and practice of which the profession should be educated. As to the relative value of two very different surgical procedures for the cure of fibroid enlargements of the uterus, he says: "I



feel that I am confronting one of the most difficult questions in abdominal surgery armed with imperfect weapons. Medicine has long and vainly endeavored to deal satisfactorily with this disease, and now the surgeon's aid is invoked. I do not deny that many cases have been relieved by medical treatment, and that some have been cured while under such treatment. I do think, however, that it is an open question how many of the cases cured while under treatment were cured by the treatment, and I believe the majority of such cures have been due to the coincident interposition of Dame Nature.

"A very large number of patients never suffer pain, or even inconvenience enough to make them consult either physician or surgeon. But admitting all this, there undoubtedly remain a large number of cases urgently demanding surgical aid. Some patients are brought face to face with death from hæmorrhage, excessive growth of the morbid elements, or constant interference with rest from pain and discomfort. Others are gradually but surely reduced in strength, and have lesions of vital organs as the result of constant pressure and displacement. When surgical treatment is spoken of, we are told that we have no right to interfere with fibroids as we do with ovarian tumors, because the latter surely kill if left alone and the former do not. I am certain that this argument is only partly true, and everyone who sees a large number of cases will bear me out in the statement that numbers of women die every year from the direct and indirect effects of fibroid enlargements of the uterus.

"I would ask, How much of the general surgery of the day which is danger-

ous to life would continue if surgeons ceased to perform operations of expediency, that is, to operate for deformities and diseases which do not endanger life in themselves, though they deprive their victims of all the pleasures of life? I affirm, then, that there are many cases of fibroid enlargement of the uterus which endanger the lives of their bearers, and that there are many more which make these poor suffering women so miserable and useless that they are justified in running the risks of operating, and that the surgeon is justified in operating. We must remember that these operations are usually undertaken in extreme cases, and when the patients are worn out with disease and suffering.

"The operation of complete supra-vaginal hysterectomy, with removal of both ovaries, has become, when properly performed, one of the most successful of the great operations.

"Hegar and Kaltenbach, by their new extra-peritoneal method, have saved eleven cases out of twelve; and the surgeons at the Samaritan Hospital have in the last year had equally successful results, also by the extra-peritoneal method, using Koeberle's wire *serre-nœud* in much the same way that Hegar uses the elastic ligature. These operations of hysterectomy and complete supra-vaginal hysterectomy still remain, however, very formidable operations. They are terrible mutilations; the patients are slow in convalescence. Is there then no operation of less danger, of quicker convalescence, and of better and more perfect results which we, as surgeons, can recommend to our patients?

"Thanks to American surgery, the brilliant conception of Blundell, in 1823, was made a recognized surgical procedure

by Battey, in 1874, and from the labors of Hegar, Trenholm, Tait, Savage and others, I am able to present to you a perfected operation, which will render this formidable hysterectomy still less often necessary in the future than it has been in the past.

"The complete removal of the uterine appendages, when efficiently performed, cures fibroids of the uterus with rapidity and certainty. And I will ask you to remember that this operation is not such a serious mutilation, and does not leave behind it any mark except a small linear scar on the perfectly closed abdominal parietes. The removal of the uterine appendages is attended with infinitely less danger to life than are the various operations for the removal of uterine fibroids.

"Are we then justified in subjecting our patients to the formidable operation of supra-vaginal hysterectomy when we can cure them by removal of the uterine appendages?"

It should be accepted as a settled fact that we are never justified in doing a hysterectomy when the appendages can be removed early in the growth of the tumor.

#### SOME OF THE THERAPEUTIC WORK OF THE PAST YEAR.

Arsenite of copper in anæmia, the use of atropine as a hæmostatic, and the value of camphorated oil in cases of collapse have received attention. The administration of oxygen in various acute respiratory affections led to numerous communications; it was employed together with strychnine in pneumonia, alone in a severe case of broncho-pneumonia following influenza, and it was also recommended in asthma and in convalescence—massage, electricity and ox-

ygen being regarded as substitutes for change, exercise, and sea-air. Rectal antiseptic injections in epidemic influenza, and in advanced phthisis with large cavities, have once more received commendation. Phthisis has also been treated with creosote, guaiacol, camphoric acid, and cantharidates, but increased experience with the last named has given rise to some anxiety, owing to the frequency of consecutive albuminuria. In the treatment of vomiting, hydrochloric acid and strontium bromide have been recommended; chlorobrom has been used for sea-sickness and solanine for painful disorders of the stomach; orexin hydrochlorate has somewhat gained in favor as a stomachic and aid to digestion; salicylate of bismuth has been used in infantile diarrhœa, and lactic acid in many other forms of diarrhœa, having given good results even in phthisis. Much has been written of the value of glycerine in the treatment of hepatic colic, for which, when due to gall-stones, large doses of olive-oil have also been recommended.—*Ex.*

#### FOR CORNS.

The following directions for removal of corns from the feet are contributed by a correspondent to the *Brit. Med. Jour.*:

Immerse the feet for ten minutes or more in cold (or, in winter, very slightly chilled) water. Then with a strong-bladed sharp penknife gradually shave off the corn in thin slips, or a plane, with the surface, and subsequently remove any slight inequalities with a small and very fine file. The secret of success consists in the use of cold water for the immersion of the feet. Razors, small, slender penknives, and warm water must be avoided.



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BALTIMORE, SEPTEMBER 16, 1893.

**Editorial.**THE FIRST PAN-AMERICAN  
CONGRESS.

Among the many omens betokening progress in our great profession, none appeals to the American mind with more encouraging import than the Pan-American Medical Congress recently held in Washington City.

Apart from the individual attractions of its well-appointed sections, the *idea* of the Congress was itself a noble one, fit to arrest the attention of every citizen. It was a demonstration of the essential unity upon our continent of the brotherhood of the healing art. It called the attention of thoughtful men to the fact that in this Western Hemisphere there is a vast array of seekers after truth, who, refusing to turn aside after the speculations of crack-brained philosophers, and spurning the debasing allurements of unholy gain, have consecrated themselves with unexcelled devotion

to the service of suffering humanity; to the searching out of the mysteries of disease-action; to the advancement of their great profession, bequeathed them by careful observers of the past, unto the highest perfection possible in the present state of scientific and social progress.

To such an idea it was but appropriate that the governments of the peoples of the three Americas, of whatever race and tongue, should officially pay tribute in sending delegations from their medical services with instructions to participate in the Congress as their representatives.

The Congress is now over, and its records will soon be officially before the public. Much of indifferent material will doubtless be found in them, side by side with masterpieces of observation and research. But the *idea* of the Congress will live on, unsullied by the imperfections of individual sessions, gaining ever new lustre as medical education advances and medical skill rises to greater heights of wonderful attainment.

All honor to the men who devised and planned the Congress, and whose untiring industry have won for it success, adding new lustre to the fame of this most remarkable, most memorable Columbian Year of 1893.

HYPERTROPHIC PULMONARY  
OSTEO-ARTHROPATHY.

The various forms of local hypertrophy of the human body which have recently been described and named by expert medical workers are but little comprehended by the average practitioner; yet an acquaintance with their general out-



lines is very desirable, as cases are brought from time to time for treatment in family practice.

In the *Brit. Med. Jour.*, June 3, we find several cases of the above-mentioned hypertrophic disorder recorded by Dr. Thorburn, of the Manchester Royal Infirmary, who appends the following general description of the disease:

The clinical characters of hypertrophic pulmonary osteoarthropathy, as described by the French writers, are in many respects similar to those of acromegaly; but they present, nevertheless, important and sufficiently obvious differences. In the former disease the hands and feet are always greatly and symmetrically enlarged, the increase in size involving also the lower fourths or thirds of the forearms and the legs, implicating the bones more than the soft parts, and markedly the terminal phalanges, over which the expanded nails are spread out with a transverse and longitudinal curve, so as to be very convex. The nails themselves are very large, and, bending over the ends of the fingers, give these a great resemblance to the beak of a parrot; they usually present a longitudinal striation. Various long bones are often hypertrophied, especially at their ends, and effusion of fluid into the knees and other joints is common. The skull is not affected, the lower jaw, nasal and malar bones being also normal; in one case only was the upper jaw slightly deformed by thickening of its alveolus. Scoliosis is common, and it is not rare to meet with kyphosis, which affects the lower dorsal region. The disease is generally of insidious onset and long duration, and in all or nearly all cases is accompanied by some form of chronic bron-

chial, pulmonary, or pleural disease, for which reason it is described as "of pulmonary origin." From osteitis deformans it differs widely, but especially in the absence of enlargement of the cranium. Myxœdema is also perfectly distinct, and is characterized by the thickening of the soft parts rather than of the bones. A perusal of the annexed reports will sufficiently indicate that we have certainly not to deal with even atypical cases of chronic rheumatic arthritis, leontiasis ossea, gigantism, or of ordinary tuberculous or syphilitic lesions, all of which have been clearly distinguished from hypertrophic pulmonary osteoarthropathy by other writers. Finally, many of the points already referred to show that there is in this condition something more than a mere exaggeration of the common Hippocratic hand of pulmonary and cardiac diseases, and the fingers differ from ordinary clubbed fingers in that the main enlargement is not terminal and that it is unaccompanied by cyanosis.

The only real difficulty in diagnosis hitherto encountered has been in the differentiation of hypertrophic pulmonary osteoarthropathy from acromegaly; and the latter is distinguished chiefly by the more uniform and proportional hypertrophy of the fingers, the relative smallness of the nails, the large size of the carpo-metacarpal region as compared with the wrist, the analogous condition of the foot, and the normal size of the radius and tibia. In acromegaly also the hypertrophy is not so distinctly limited to the bones; kyphosis, when present (as it usually is) affects the cervico dorsal and not the dorso-lumbar region; the lower jaw is greatly deformed, causing marked prognathism; the nose, lips, tongue, neck,

larynx, and ears are often enlarged, and there are defects in speech, mastication, and deglutition. All of these characters are conspicuous by their absence in our disease. Acromegaly further presents no essential connection with chest affections, but is commonly accompanied by, if not due to, enlargement of the pituitary body, with consequent visual and cerebral troubles. Other minor distinctions have been made; but in the present condition of our knowledge of the subject, a too great refinement of detail would appear to be dangerous, and a broad view of every case under consideration is more likely to lead to a correct conclusion as to its nature.

The disease is almost confined to adult life, but three cases are recorded in children, of whom the youngest (Gillet's case) was seven years old. Equally marked is its tendency to affect the male sex, there being only two females among the total of thirty cases. The onset is generally gradual, and the time of its commencement usually quite uncertain, so that in some cases there appears to have even been a congenital tendency to the development of large extremities. In other and fewer cases there is a clear history of a sudden and rapid course, as in the case recorded by Saundby, in which some four months appeared to have sufficed for the development of a typical condition. In my own first case, in which the history is the most complete, the growth commenced somewhat rapidly, and, having reached a certain point, became much slower, so as to leave an almost stationary condition.

#### PROGNOSIS AND TREATMENT.

No intrinsic danger to life accompanies the presence of this complication

of pulmonary disease; but, the primary and causal condition being of necessity generally fatal, the ultimate result cannot be observed. There is, however, certainly no tendency to acute inflammation or to suppuration of the affected bones and joints. Of treatment we can say little, except that in a case of Moussois's, in which an empyema was accompanied by a slight degree of hypertrophy of the extremities, the antiseptic irrigation of the pleura was followed by a diminution in their size; and in Gillet's case improvement followed the drainage of an associated tubercular vomica, so that there is reason to suppose that the relief of the pulmonary condition is not without beneficial effect upon the complication.

For these various reasons I would suggest that hypertrophic pulmonary osteoarthropathy is in reality a tubercular affection of a large number of bones and joints, but that it is of a benign type, having no tendency to break down or caseate. It appears in fact to bear to the common "strumous" lesions of joints a relation similar to that which lupus bears to "tuberculous ulceration" of the skin; and also, like lupus, it is widely diffused, with a tendency to be symmetrical and to affect the extremities, possibly because the comparative feebleness of the circulation here favors the growth of bacilli, which have a precarious existence in the body. Should this view ultimately prove to be correct, we might, with advantage, substitute for the cumbersome but guarded designation of Marie, the term "tuberculous polyarthritis."

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For epilepsy, try strontium bromide,

## Medical Progress.

### COCCYODYNIA.

At a recent meeting in Richmond, Dr. Waldo read (*Gaillard's Medical Journal*) a paper reporting a case in which this obstinate disease was cured by removal of the coccyx, and in connection with it exhibited some small pieces of ossified material which had been found in the ligaments on either side of the coccyx.

The case had been referred to him by Dr. Malleson in March of the present year. Some months ago the patient had a fall on the stairs, and was confined to bed on account of pain and a fever which at times reached 103°. She did not know that the coccyx had been injured, and after trying all the ordinary methods of treatment in the hope of relieving the severe pain over the coccyx, she entered the Lebanon Hospital, and an examination under ether showed the uterus and appendages to be normal, but there was evidently an ununited fracture of the coccyx. On March 16 the operation for the removal of the coccyx was performed. In these operations on the spine, it will be found that just as one cuts down to the bone, and begins to use the bone forceps, the wound is apt to suddenly fill so quickly with blood as to lead to the supposition that some large artery has been cut; but in reality the hæmorrhage is venous, and is best controlled by making pressure with sponges for a few minutes. The easier method of operating is to begin from below and work upward, but it must be remembered that the rectum lies against the coccyx, and is liable to be injured. In this case he closed the

wound entirely, merely placing several pieces of silk-worm gut at the bottom of the wound. These were removed after two or three days, and at the end of the seventh day, primary union having been secured, the sutures were removed. The bowels should be moved not earlier than the third day, and the stools should be quite soft. The rule in these cases is not to get primary union, but much depends on strict antisepsis and the after-treatment.

Coccydynia was first described in 1844 by Dr. Mott, of this city, as a separate disease, but it did not then attract much attention until 1861, when Sir James Simpson wrote quite extensively on it. When the operation is done for neuralgia the results are usually *nil*, and this has brought the operation needlessly into discredit. The result is far different, however, when it is done for fracture. This patient had no coccygodynia by the second day after the operation.

### TRAUMATIC NEUROSES.

In this age of rapid transit in city and in country, this subject takes on added interest. In the *Univ. Med. Mag.*, July, Dr. Potts declares himself as follows:

It cannot be denied that neurasthenia, when produced by overwork, exhausting disease, or any of the many other recognized causes for such a condition, may cause great suffering and disability when only subjective symptoms are present; and these cases would seem to prove that traumatism of greater or less severity should be placed among those causes. That hysteria is a genuine disease and not a synonym for simulation, there is no question among neurologists. The



doubter is referred to any modern work upon nervous diseases.

Therefore, as among the principal reasons for which compensation is awarded after accidents are the pain and disability caused, it is no more than reasonable that such cases, being injuries to the nervous system, are as much entitled to receive such compensation as one who has received a broken leg. The question may be asked, "How will we tell the malingeringer from the *bona fide* case?"

#### FOR HERNIA IN CHILDREN.

In his recent address before the American Medical Association Dr. Mudd (*Gaillard's Med. Jour.*) said:

A permanent cure of hernia is often brought about by the use of a truss, and this measure should always, when possible, be given a trial. In the case of adults, however, the conditions are different, and a radical cure by means of the truss is an improbable event. The very fact of the multiplicity of methods advocated for the radical treatment of hernia is a proof that the problem has not yet been satisfactorily solved. The mortality attending the operation is so low (about one per cent.) as to justify its undertaking. If the majority of cases are permanently cured, making all necessary deductions for ultimate relapses, it may be stated that permanent recovery ensues in from sixty to eighty per cent., a sufficient number to justify the operation. Of all the methods, that of MacEwen alone permits of the retention of the hernial sac, for it is generally agreed that the obliteration of the sac is essential to a perfect result. The important point in guarding against the recurrence of the hernia is the destruction of the normal irregularity in the abdominal wall

formed by the transversalis fascia and the muscles at the internal abdominal ring. This can be most effectually accomplished by closure of the canal and removal of the cord to a new point for its passage through the abdominal wall. Operators differ in their choice of the opening for the cord, but the preferable point would seem to be one to the outer side of the canal near Poupart's ligament. In certain cases, however, it may be better to carry it well in toward the median line. The union of the tissues of the weakened abdominal wall should be sought by primary union, rather than by granulation, as the former is stronger. The speaker preferred buried animal sutures to permanent sutures of silk or wire. The following were Dr. Mudd's conclusions: 1, the mortality should not deter us from encouraging the operation for the radical cure of hernia; 2, the percentage of recoveries is sufficient to justify it; 3, the removal of the sac is an essential feature of the operation; 4, the approximation of the tissues in the weakened abdominal wall is no less important; 5, the surgeon cannot urge the operation in every instance, but may perform it in the great majority of cases where a truss does not sufficiently control the hernia.

#### VESTIGIAL CANCERS (BLASTOMATA).

An interesting article on cancers is given by Dr. Snow, of the London Cancer Hospital, in the *Lancet*, July 29, in which he groups as follows those cancers which seem to have begun in residues of embryonic tissue. He says: A definite differentiation of cancers of the vestigial group, on which I have ventured to confer the title "blastoma," is demanded by the existence of an ob-

scure section of cancer cases, numerically very small in proportion to the rest, which conspicuously differ from the latter in histological composition and generally also in the period of life at which they appear, and which can be traced to some partially obliterated fœtal organ or else to some persistent cells of the "blasts" concerned in the development of the embryo. Such fœtal remains may persist throughout life in a perfectly innocuous form, others constitute palpable tumors without any malignant attribute. A substantial proportion, however, after a term of existence in a quiescent state, suddenly increase, and unless surgically dealt with prove fatal, with all the symptoms of true cancer. Nearly all the malignant lesions of childhood and early youth belong to this congenital division. The group of organs which are the most conspicuous offenders in this respect are those derived from the Wolffian body with the Mullerian ducts and germinal epithelium; such are the kidneys, uterine appendages, testes, vesiculæ seminales, epididymis, prostate, vas deferens and cortical portion of the adrenals. Ovarian dermoid cysts are a familiar class of tumors; but it is not so well known that they are either actual or potential cancers, prone to emit secondary metastases, and when ruptured into the peritoneal cavity to generate auto-inoculative grafts; very likely also to recur after removal. Various examples are cited by Mr. Bland Sutton in his valuable work on "Surgical Diseases of the Ovaries and Fallopian Tubes." Perhaps the most instructive case is one by Dr. Fraenkel. A woman aged thirty-seven fell and ruptured an abdominal

tumor, which had been noticed for two years; there was subsequent peritonitis and rapid increase in size. Eventually the cyst was found to have been a dermoid, grafts from which had taken root over nearly the whole peritoneal surface and were growing luxuriantly as pedunculated masses. Some of the smaller contained fine hairs. Mr. Bland Sutton proposes the name "oöphoroma" for these congenital ovarian lesions, and significantly points out that their degree of organization varies with the age which the individual has attained, being most embryonic in early infancy; whilst towards puberty the new tissue tends to "assume an alveolar arrangement." A similar devolution tendency is shown by the derivatives of the male Wolffian body. Dr. Bertram Windle has demonstrated the congenital source of "many, if not most," of the malignant new growths found in the kidney during early life. In eleven of his forty-one cases the tumors contained striped muscle (rhabdo-myoma); the remainder differed from the ordinary sarcomata of adults in their mixed structure. So also the bladder tumors of young children contrast with those of the adult in their complex histological composition; they may contain such heterogeneous elements as striped muscle and cartilage.

The retinal glioma of infancy similarly needs differentiation from the cancerous diseases (generally sarcomata, more or less pigmented), which attack the eyeball in adult life. Its age-limit appears to be twelve years; it may commence in utero; both eyes may be synchronously attacked. Tumors of the soft palate, of the parotid, &c., furnish



another section of the blastomata. The latter are important as showing that the malignant reversion may here be delayed till advanced age; whereas in the ovaries, kidneys, bladder and adrenals the patient is almost invariably youthful. The thymus is a vestigial organ, whose remains frequently develop malignancy; the lesions are often polymorphic. About the spinal cord and medulla are found tumors reproducing the structural characters of intestinal cancer (cylindroma), the central nervous system and alimentary canal having both arisen from a primitive U-shaped tube. Uneffaced traces of the six obsolete foetal canals—practically sequestered portions of bowel—often prove the source of quasi-malignant new growths. Such obsolete rudiments as the pineal and pituitary bodies are occasionally the site of tumor development. In some of these cases the cancerous nature of the lesion would seem to have escaped recognition only because life has been quickly terminated by local pressure-effects before the emission of metastases.

When malignant phenomena supervene in a tumor arising from any foetal remnant they seem to do so spontaneously, in virtue of some inherent reversionary force. The best illustration of the principle is afforded by the rhabdomyomata of the kidney—rapidly growing cancers, containing sarcoma elements blended with striped muscle fibre, sometimes with various other heterogeneous tissues, and usually fatal within two years after birth. This characteristic affords a very important distinction between most of the vestigial blastomata and cancer of the ordinary type in adults. For in the latter no predisposing con-

genital element can be discovered; and the previous operation of a more or less extraneous exciting cause is always evident if duly sought. The clinical characteristics which stamp a tumor as of the blastoma order are sometimes an obvious congenital origin, as when the disease has commenced in utero; development from an obsolete foetal organ, such as the thymus, pineal and pituitary bodies, parovarium, coccygeal body or other relic of primitive intestine, &c., simultaneous appearance in bilateral structures, as in both kidneys, or both retinae; occurrence in early childhood without obvious cause, especially when in one of the derivatives of the Wolffian body. The histological and microscopic characters of neoplasms ranking in the group vary considerably. The most common and most salient characteristic is polymorphism, a curious and complex mixture of the most dissimilar and unrelated tissues; of carcinomatous or epithelial cells, with the embryonic spindle elements of sarcoma; of tubules or cysts lined by cubical epithelium with areas of diffuse cell infiltration; or glandular acini or crypts, with tissues of the connective order, bone, cartilage, fat. Thus the cartilage common in parotid tumors proves their congenital parentage, being developed from remains of the structure known by the name of Meckel; so cartilage and even true bone are occasional constituents of obscure tumor formations in the mamma, scrotum, rectum, &c. Some of the blastomata may seem not microscopically to differ from ordinary malignant lesions; thus they have hitherto been classed as sarcomata, especially as "round-celled sarcoma," as "columnar-celled epithelioma," as "ad-



enomata," "angeio-sarcomata," "chondro-myxosarcomata," as cysts or sarcomata, pure and simple, &c. The bewildering variety of names testifies to the obscurity of their structure, as well as to the need of differentiation as a special group. The polymorphism is usually apparent upon microscopically examining sections from different parts of the growth; it reaches its acme in the "mixed embryonic tumor" of Cornil and Ranvier, which is composed of embryonic connective-tissue, cartilage, striped muscle, bone, tubes lined by cylindrical epithelium, lobules of pavement epithelium and cysts.

#### ELECTRIC DILATATION OF STRICTURE.

We believe in the future of electricity; therefore we refuse to follow the lead of surgeons who pass final unfavorable judgment on electrical methods in any department in which we might reasonably expect aid from its subtle might.

We excerpt from the *Jour. Amer. Med. Asso.*, April 15, a few paragraphs of Dr. Robert Newman's tabulated review of the results of his third series of 100 cases of urethral stricture treated by aid of the electric current. He says:

The writer has practised this method of electrolysis successfully for over twenty-three years, and has already described the *modus operandi* and instruments, and laid down rules minutely for the operation. It is unnecessary, therefore, to recapitulate them again. The leading features for the operation being that the constant current of galvanism only must be used, always applying the negative pole to the seat of the stricture, using only weak currents of from three to five milliampères, seances

lasting not more than from five to ten minutes, with intervals of about one week or longer. Only one instrument should be used at each seance, and the operation ought never to be attempted while the mucous membrane is in a state of inflammation. The patient's strength should not be overtaxed, and gentleness should prevail through the whole operation. As a matter of course, only the best instruments should be selected and used.

The advantages of electrolysis over other operations are confirmed by the new cases now presented, namely:

1. That it is applicable to all strictures in any part of the urethra.
2. That it will pass and enlarge any stricture when other instruments or the skill of the surgeons fail.
3. That it causes no pain or inconvenience.
4. It is devoid of danger.
5. It is not followed by hæmorrhage, fever, or any other unpleasant consequences.
6. It relieves at once.
7. The patient is not prevented from attending to his business while under treatment, and is without restraint; and
8. No relapse takes place.

The electrolytic method may not for some time become so popular that every general practitioner will use it, since it needs, beyond skilfulness, great patience, gentle touch, good instruments, and electric apparatus in perfect order, also the qualifications of a master electrician and genito-urinary expert.

We believe that this article may be obtained in reprint form on application to Dr. Newman, 68 W. Thirty-Sixth St., New York.

## MALLET-FINGER.

The deformity here described is not uncommon among men who engage in athletic sports.

When the extensor tendons of the fingers are tense, a blow upon the end of a finger transmitting force in a direction which would ordinarily flex the finger, results in injury to the extensor tendon in the vicinity of its attachment to the dorsal surface of the last phalanx. The injury consists, not in a bodily separation of the tendon from its points of attachment, but rather in a thinning of the tendon cephalad from the principal point of attachment to the phalanx, and from the fibers that form the posterior ligament of the last phalangeal articulation. A few fibers of the tendons are undoubtedly ruptured, but most of them slide away from each other very much as the threads of a textile fabric separate when the fabric is violently stretched, but not torn, the structure retaining its original general appearance.

Immediately after the occurrence of the injury to the tendon the last phalanx of the finger assumes a semi-flexed position, and the deformity is usually permanent, the extensor tendon then having little or no influence upon the freed phalanx. Aside from the uncanny appearance of such a finger, the deformity is a source of much annoyance to the patient.

The tendon is repaired without much difficulty by making a longitudinal incision two centimeters in length over the site of the injury, dividing the thinned tendon longitudinally into the two principal fasciculi into which it naturally separates, dividing the tendon transversely, cephalad from the thinnest point,

and advancing each fasciculus to a point upon its own side of the finger, near the base of the finger-nail. At this point the fasciculus is sutured to the under surface of the skin with a suture which passes through the skin, and is tied upon the outside. The fasciculi are sutured to skin rather than to periosteum and tendinous remains, because the former structure affords a firmer hold and the cut end of the tendon makes as good union with the phalanx as it would if sutured directly to periosteum.

The finger-nail is sometimes lost temporarily as a result of the operative disturbance near its matrix.

When the advanced fasciculi are sutured in place there is an over-correction of the deformity of the phalanx, which causes also a flexion at the middle phalangeal articulation. This condition is temporary, and disappears spontaneously in a few weeks, leaving a perfect finger.—Dr. Morris, *Med. News*, Sept. 9.

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### Medical Items.

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Dr. Henry McElweed died at Lowmoor, Allegany County, last week. He was a graduate of one of the Baltimore medical colleges and was a successful physician.

Don't take your pen in hand till you have something to say which is liable to interest a good many people, and don't be hasty or careless in your way of saying it.—*Ex.*

Dr. Hiram Woods has removed his office from 525 N. Howard Street to 816 Park Avenue, north of Madison

Street. Office hours, 8 A. M. to 1 P. M. Sunday to 10.30 A. M.

Myrrholin is a solution of one part of myrrh in one of oil, and is said to have given good results in tuberculous laryngitis; it is administered in capsules containing 0.20 gm. of myrrholin and 0.30 gm. of creosote.—*L'Union Pharmac.*—*Ex.*

Hereafter physicians in New York, attached to any hospital, can give their testimony before a referee, instead of being compelled to waste time in attending court, in the case of patients in the institution with which they are connected. It strikes us that this ruling is in the interest of justice and medical men.—*Ex.*

Migraine may be relieved, Lucking says, with a pill, twice daily for some time, consisting of Indian hemp one-sixth grain, phosphide of zinc one-tenth grain, and arsenic one-thirtieth grain. The severity of the attack may be effectually diminished with liquor trinitrinæ in minim doses two or three times daily.—*The Clinical Journal.*—*Ex.*

Dr. J. T. Whittaker, in the *Journal of the American Medical Association*, calls attention to the headache induced by gonorrhœa. It is most common in cases in which the posterior urethra is attacked. With the headache are restlessness, insomnia, jactitation, etc. These cases require topical treatment by the catheter, which carries nitrate of silver to the prostate gland.—*Ex.*

A Paris wet-nurse has had an unpleasant experience. The Assistant Publique sent her an infant to nurse, from which she contracted syphilis. It was shown

that the woman and her husband, prior to the arrival of the infant, were free from disease, and the woman had therefore no difficulty in establishing her case and securing 7,000 francs as damages.—*American Lancet.*

In the movement to provide recreation for the city children during the hot season it is pleasant to know that the Home of the Friendless Children has not been forgotten. We are informed by the *Sun* that nearly a hundred happy children from the Home of the Friendless, Baltimore, enjoyed a day's picnicking in a pine grove, near Belair, last week, under the auspices of the Woman's Christian Temperance Union and King's Daughters of Belair. Lunch was served to all, and the little ones, composed of sixty boys and thirty girls, ranging from six to twelve years, seemed to enjoy themselves immensely. They all returned to the city by the late train.

A man stepped into a grocer's shop to make a few purchases. While the clerk was weighing the goods the customer could not resist the temptation of treating himself to a piece of sugar which was lying on the counter. The clerk observed the action, and soon afterward, with startled mien, called aloud in the shop: "What has become of that lump of arsenic that was lying here?" The poor fellow felt hot and cold, and in his terror confessed the deed. "You are a dead man!" said the pert clerk; "but I have here an antidote. Quick! take as much of this as you can swallow." And he filled a tumbler full of salt and water. The poor fellow eagerly drank off the abominable stuff to save his life if possible. He then rushed out in order to secure



a second antidote from a neighboring pump. He has never been known to pilfer sugar since that day.—*Ex.*

The abominable diaper is unknown to the Japanese. They use only a breech clout, which is removed at the moment of defecation. The child is then put in such a position that its legs straddle the arms, its body and head resting against the abdomen of the parent who, gently rocking it in a certain rhythmical, tentative fashion, and accompanying this action with a kind of low whistling, reminding you of a lullaby, gives her offspring its first lesson in personal cleanliness, which to the Japanese mind is exceedingly near to godliness. It will be seen how by this method unnatural positions are avoided, a thing the more important that Japan is the country of worms, distomata, etc.—Dr. Ashmead, *University Medical Magazine*.

For the treatment of obesity in a person whose heart and arteries are sound, Dr. Dujardin-Beaumetz recommends the following method:—Every morning a general body-sponging with hot eau-de-cologne and water, followed by dry rubbing and massage. A tumblerful of purgative water is then administered. At the end of each meal a dessert-spoonful of the following solution is swallowed: 15 grammes of iodide of potassium and 250 grammes of water. The undermentioned regimen is to be rigorously observed: First meal, 8 A. M., cup of chocolate, 20 grammes bread. Second meal, two eggs, or 100 grammes meat; 100 grammes green vegetables or salad, 15 grammes of cheese, a little fruit, 50 grammes of bread, one glass and a half of liquid (a light white wine with Vichy water). Third meal at 7 P. M., no

soup, 100 grammes of meat, 100 grammes of green vegetables or salad, 15 grammes of cheese, fruit, 50 grammes of bread, one glass and a half of liquid (white wine with Vichy water). No drinking between meals, no tea, no coffee, cognac or other alcoholic beverage. Plenty of exercise in the open air.—*Lancet*.

"I wish when people ascribe the cause of fire to a defective flue they would be more explicit," said an anxious house-keeper, "and tell why they had cause to believe that it originated in that manner, and in what way the flue was defective. It is very uncomfortable to think that fire may break out at any time under one's floors or in the walls, despite the greatest vigilance." "I can tell you of one danger that is generally overlooked," said a friend, "and that is in letting inflammatory substances fall through the register. The other day I had a case of china unpacked in the dining-room. The box was filled with 'excelsior' packing, and after the dishes had been taken out I told the maid to clear up the litter on the floor. A little later I came into the room and smelled a strong odor of burning; it was a very cold day, and there was a hot fire in the furnace, and, as the smell seemed to come from the register, I lifted it entirely out and stuck a bent poker as far down the pipe as I could reach. With a lot of dust and rubbish, I brought up a quantity of excelsior shavings which were distinctly scorched by the heat. It was the first time that I had ever thought of the danger of 'sweepings' connected with the open registers, and I at once called my waitress and bade her in the future to be very careful and invariably close the register before sweeping."—*Ex.*

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## Original Articles.

### THE PRESENT STATUS OF DRUG THERAPEUTICS AS APPLIED BY THE GENERAL PRACTITIONER.\*

BY A. K. BOND, M. D.,

Lecturer on Diseases of Children in the Baltimore Medical College.

In this, the last decade of the nineteenth century, when specialism is growing apace and threatening to cover with its branches the whole field of applied medicine, it seems proper that we should turn our eyes for a moment from the contemplation of its wonders, and view the progress of bedside therapeutics in the practice of the family physician.

For family practice is not yet a thing

\*Read before the Medical and Chirurgical Faculty of Maryland, April 26, 1893.

of the past, nor does it yet show signs of fatal decay. While the wonderful revelations of bacteriology have been the delight of the physician's leisure hour; while the triumphs of surgery as spread on the pages of the medical and secular press have filled the profession with admiration, and the laity (especially the feminine contingent) with a desire to be operated upon; the family physician has quietly and observantly as ever borne the greater portion of the burden of caring for suffering humanity, of relieving its pains, of piloting its frail barks through the tempest of disease, and of soothing and comforting its soldiers who have been mortally wounded in the last great conflict of earthly existence.

The family physician is conservative; well it is for the public that he is so;

yet he is ever advancing. Much has he gathered from the researches and experiments of specialism; much has he learned from his own observation at the bedside of his patients—observation that from year to year becomes more systematic, more acute, more judicious.

But my chosen theme on this occasion is the therapeutic application of pharmaceutical remedies as it is seen in family practice. Is it creditable to this age of scientific attainment, of intellectual culture? Above all, is it securing the results which may reasonably be expected of it in the hands of the intelligent, well-trained, conscientious general practitioner? I ask your patient attention for a brief period to the consideration of these problems.

First, as to the agents themselves. Has the supply of pharmaceutical remedies kept pace with our increasing knowledge of disease? Without hesitation I answer "yes." In no department of our great calling have more remarkable improvements been made during the last fifty years than in the department which provides remedies for bedside use. The variously coated pellets of the great manufacturing houses are to me a continual wonder. The accuracy of subdivision, the uniformity of size, the thinness, yet protective power, of the coating, the resistance to atmospheric changes, presented by modern pharmaceutical globules would be a credit to any branch of the mechanical arts.

In the great pharmaceutical laboratories, enthusiasm for investigation and discovery has reached the highest mark. No longer content with the mineral salts familiar in the chemical laboratory of the university, no longer satisfied with

concoctions and infusions of garden herbs, the pharmacist has pushed out in all directions as a pioneer. Nearly every herb and plant of civilized countries has been studied, its virtues extracted, its alkaloids and active principles isolated and efficiency tested; and into foreign lands skilled botanists have been sent to study the properties of the plants famed among the natives for medical virtues. Nay, even into the great unknown, the land of faith and speculation, the pharmacist has made his way; and, reasoning from that which is to that which is not yet, he has actually predicted beforehand what the as yet non-existent resultant of chemical combination will be like; and by introducing definite groups of atoms into given compounds has produced drugs with therapeutic properties answering to his previous calculations. Already a long list of remedies of beautiful physical properties and decided remedial virtue have resulted from these pharmaceutical speculations; more are forthcoming every month, and all persons who have studied the theory of the "carbon compounds" will admit that this field of research is vast enough to furnish material for profitable investigation throughout all time.

Great groups of useful remedies are now at the command of the physician. Would he stimulate the flagging heart, would he control its overaction, would he quicken the secretion of the respiratory tracts, or quiet the restless brain, or promote drainage of stagnant fluids by the lymphatics, or excite the action of muscular tissue, or soothe the anguish of the sensory nerves, at once a host of agents lie ready to his hand. Nay, it is even within his power to lead the un-



conscious patient safely along the narrow ledge which severs life and death; and many a time has even the least-skilled physician reached out into the gulf of shadows and brought back to life one who was almost lost.

These achievements of bedside therapeutics are so familiar in the daily practice of the physician, that he underrates the wonderful power committed to him by the Ruler of the Universe, and even suffers ignorant, unthinking persons to sneer at his high calling, and to speak as if medicine were a senseless and unprogressive medley of crude and cruel experimentations. Nay, rather let us honor our profession and be ever ready to uphold her dignity.

But does the *application* of drugs in the daily practice of the intelligent physician bear out his claim to scientific culture? Is it creditable to this era of modern progress? These questions deserve careful investigation and judicious solution. I myself believe that the answer must be in the affirmative. The practitioner (I am not now speaking of those who have a genius for advertising their cures) may, himself, at first hesitate in his response. His attention is so absorbed with his few failures that he quite forgets his many successes. Exactly what percentage of prescriptions may be considered as attaining the needful result and hitting the mark toward which they were directed can only be guessed. But it is probable that in the hands of the skillful practitioner nearly every drug given to patients with whose peculiarities he has had time to become familiar produces the desired effect in cases where the body has not yet ceased to obey the helm of the nervous system and where

the drug given is taken up by the absorbents. This statement implies that very many of the discouraging failures of the untaught or inexperienced practitioner might be avoided.

Let us consider then the sources of failure which occasionally occur in the practice of the best physicians and very often occur in the practice of those who are unskilled. We may divide them into two groups:

First, those failures which are *avoidable* by the physician.

At the head of this group must be placed the therapeutic failures which result from *inexact diagnosis*. As far as this is due to deficient training, we may hope that lengthened curricula, and higher graduation tests, may in future correct it. As far as it is due to the youth of the physician, advancing age and consultation with older doctors alone can remedy the evil. With reference to errors of diagnosis, and consequent therapeutic failure, due to carelessness in examination of the patient, we may confidently predict that they will become less and less frequent as time goes on, since increasing competition will force careless men to the wall, and energetic, thorough workers will take their places.

Next to inexact diagnosis we may mention as a cause of therapeutic failure a certain *deficiency of comprehension* of the case, which is seen in physicians whose minds are unable to take in all the bearings of an ailment and with keen insight to detect the underlying causes of the disturbance of bodily function. This defect of mind can only be corrected by a careful preliminary education before entrance upon medical studies, and by a cultivation of the philosophic side of

medicine, which is in our young nation, with its rapid-transit schools, now wholly neglected.

And here we are brought face to face with another avoidable source of therapeutic failure—the *drug-booming* with which we have been so woefully afflicted of late. Even the family practitioner, farthest removed from the temptation of sensation-hunting, has been sorely tempted to follow the lead of writers and teachers whose extravagant assertions concerning the virtues of the latest remedy imported from Europe ought to show the incompleteness of their diagnosis or the unreliableness of their judgment. The sudden rise and fall of drugs in professional estimation is one of the surest indications of a want of sober, comprehensive thought among medical men. It is possible that the new-drug fads of recent years have really turned back the hands of therapeutic progress, by diverting the attention of medical men from the tedious and less interesting labors of serious therapeutic study. The bursting of one glorious therapeutic bubble after another must also beget therapeutic scepticism in sensitive minds, as it begets mercenary tendencies in minds less scrupulous.

Therapeutic failure sometimes occurs, even after a correct diagnosis has been reached, as a result of *imperfect acquaintance* with the individual drugs used.

When so many of the statements made in journals, and in the prematurely delivered and immature books which are sold by thousands in our literary shambles, are pure falsehoods or half-truths, it is very evident that the physician who seeks therapeutic excellence in practice must study his drugs for himself. Taking up,

one by one, first the better known and then the less familiar drugs, he should by careful observation in appropriate cases learn the virtues and the limitations of each. He will thus be able to employ his drugs with definite purpose, and with far better results, and will, furthermore, find an interest in therapeutics to which the employer of “shot-gun” prescriptions is an utter stranger. There is nothing in science more delightful than the application of therapeutic knowledge gained in one case to another case slightly differing in symptoms, yet probably involving the same essential causes as the first. Next to faulty diagnosis, lack of definite knowledge of the action of individual drugs is perhaps the greatest cause of therapeutic failure.

But while the physician should avoid the absurd medleys known as shot-gun prescriptions, he should take much interest, after learning the powers of single drugs, in studying the influence of their judicious combination. This is necessarily a very weak point in the ill-trained practitioner, since he does not even know the separate properties of the drugs. The judicious combination extemporaneously of drugs to meet clinical necessities is an indication of very advanced therapeutic skill, and is an attainment of which a physician may well be proud.

The last avoidable cause of therapeutic failure which needs our attention now is the *evanescence of knowledge*. The introduction of printing gave the world the means of preservation of important truths. The development of printing at the present day threatens to overwhelm the important truths of therapeutics, and bury them beneath heaps of

"literature," almost as soon as they have been discovered.

There is a tendency in modern progress to cast away the gems of the ages in the wild scramble for the glittering pebbles of the hour.

The best physician is he who can on occasion bring out of his storehouse agents both new and old and use each with skill and wisdom. Many a country physician is to-day gaining therapeutic victories with his "old preceptor's" remedies, which are now quite unknown to the leaders of medical thought, but will be rediscovered and be famous again in generations to come. We should never neglect an opportunity to place on our library shelves the best therapeutic works of the past. Observations there garnered may aid us greatly in the treatment of difficult cases.

It is impossible to form a fair estimate of the position of drug therapeutics, unless we take into consideration the *unavoidable* sources of failure (unavoidable, that is, as far as the individual physician is concerned).

One such important source of failure is the *impurity* of the *drugs* furnished by the pharmacist. Many untoward results in therapeutics have been due to the inability of the chemist to obtain drugs free from all contaminating association with other substances. This difficulty has less and less weight in therapeutics as the resources of the manufacturer are increased, and with the cheapening of manufacture less and less temptation to willful adulteration by the local pharmacist will be offered. Since the establishment, however, of the manufacture of pills and tablets by wholesale, a new danger has arisen.

Repeated analyses of certain pills made for sale by large manufacturing houses have revealed very serious underweight of the therapeutic agents contained in them. Against such sources of failure the physician may best be protected by the honesty of the pharmacist who supplies his patients or himself with drugs.

Another source of failure in therapeutics over which the physician has only indirect control is the *imperfect absorption* of drugs. If medicines could always be thrown hypodermically into the blood and lymph streams of the body, this element of uncertainty in practice would be eliminated. But, as a rule, medicines must be applied through the digestive canal, and their efficiency must depend primarily on the absorbing power of this tract at the time of administration. The importance of this factor cannot be overestimated. Of itself it removes bedside medicine from the sphere of physical law; rendering all efforts to establish mathematical relations between dosage and therapeutic effect of no avail, by the introduction of a varying unknown quantity dependent upon, not the laws of matter, but the laws of life. For this reason, among others, the family physician has, all down the ages, laid great stress on the use, in the beginning and course of sickness, of agents which put the disturbed digestive canal into the best condition for absorption of medicines. The therapist who refuses to recognize this necessity will certainly fail of the highest attainment as a practitioner.

The investigation of the best methods for combination of solutions and dry remedies so that the most rapid absorption may be secured lies as an almost



untrodden field of research before the therapist. A careful study of the favorite prescriptions of great therapists will probably show that their success depends largely on the addition to the active remedies of agents which promote absorption of the medicine by the digestive canal. Since solutions are more ready for absorption than powders or pills, the use of tablets to be administered undissolved must ever fail to fully meet the requirements of general practice.

Turning now from the consideration of the drug itself, we find several unavoidable causes of failure in the vital conditions of the patient himself. His hygienic surroundings may be such that the efforts of the physician which would under normal hygienic conditions succeed are partially or wholly fruitless. In a city like Baltimore, which is largely situated upon ground not properly drained, there are thousands of dwellings with damp walls and wet cellars which, if on the lower declivities of the hills, are liable to be permeated by seepage from cesspools on the slopes above. Even with the best medical care, disease and death keep the upper hand in such dwellings.

Moreover, in many cases the personal habits and occupations of patients are incompatible with health, and with the steady sweep of an ocean current baffle every effort which the physician puts forth. How can occasional doses of the best directed therapeutic remedies be expected to relieve a patient whose whole life is lived in disregard of the common laws of health? And even if the life of the patient himself is in accord with hygienic principles, there may be vices of consti-

tution handed down from generations past, which are incompatible with full health. Premature birth, defective nervous system, a gouty habit, a heart or pulmonary artery too small, may have predestined the patient to a life of invalidism.

Many therapeutic failures are due to *want of confidence* in the physician. The prescribed course of treatment is but half followed, and no benefit is obtained. The tendency of many persons to flit from one "splendid doctor" to another is to be condemned. Long acquaintance with the patient is often necessary to enable the physician to understand his mental and moral peculiarities and to gain that respect which is indispensable, if the patient's will is to be aroused to the mastery of over-prominent subjective symptoms. Especially in those cases of illness which are aggravated by worry and discouragement concerning domestic or business affairs is the influence of a tried physician-friend of value. Even if the thousand-dollar check which would at once remove the disease is not at hand, a few words of hope and encouragement do more than drugs. The unfamiliar doctor, however skillful, being ignorant of the cause of the trouble, only wastes his remedies in futile efforts to relieve.

And, finally, among the unavoidable sources of therapeutic failure, are the *changes of age* and of *protracted disease*. How often are we asked to relieve the waning strength, the flagging digestion, the sleep-limitation, of increasing age? How often do we stand in despair before the inability of a stomach with atrophied mucous membrane from long abuse or chronic disease, to digest the food neces-

sary to health? These cases are beyond hope of perfect cure; the best that drug therapeutics can be expected to do is to patch up what remains of the wrecked organs and to render their labors somewhat less onerous.

Let us consider now the probable future of drug therapeutics.

I do not expect that disease will ever be banished from the earth by the perfecting of the medical sciences. The banishment of disease presupposes a radical change of human nature, so that from birth to death man shall live in complete accord with the laws of health; and a change in the world of organized life about us, so that the infectious diseases shall cease to invade the human body. I see no reason to believe that either of these desired changes will take place, as long as the present conditions of terrestrial life continue.

Until the glorious advent of the new era foretold in Scripture shall be consummated, the physician will have abundant field for the exercise of his beneficent calling. As far as I know, no disease has been wholly banished from civilized communities by the advance of medical science. The best that has been attained by sanitary science is that certain diseases have been driven into the obscurity of the dark places of earth; but experience shows that they are ready to sally forth again if our watchfulness be even for a time relaxed. The best that has been attained by direct therapeutics is that individuals have been temporarily rescued from the clutches of some particular disease; but they are left liable to new assaults of the same or of other diseases. Even the vaunted decadence of lung tuberculosis, the "scourge of man-

kind," is said to be attended by an equal increase in the frequency of the more horrible disease or group of diseases known as cancer.

We may expect that, as long as the world lasts, dissipation, neglect of hygienic precautions, excessive mental or bodily strain, will be followed, as now, with unerring certainty, by sickness; and that each succeeding generation of mankind will learn obedience to laws of health only through the personal teaching of bitter experience.

The development of methods of therapy which do not involve the use of drugs is not likely to put an end to drug-therapeutics in family practice. The physician who has twenty or thirty patients to visit each day cannot afford the time and care necessary for the application of the former class of remedies. He needs sure, handy, manageable agents, easy of application by untrained attendants, and of moderate cost; and these requirements are met only by drugs.

When physiological chemistry shall have revealed more clearly the nature of the processes of assimilation, secretion, excretion and tissue change, a great advance in drug therapeutics may be expected.

We have thus seen that the failures of drug-therapeutics in general practice are largely due to outside conditions over which the physician can exercise little or no control. Its efficiency is daily increasing, and year by year the sources of remediable error are being eliminated.

For the present, earnest, hopeful work is needed. For by the aid of careful observation the trained worker may attain great skill in the use of the valuable remedies, old and new, which lie ready to



his hand. It should never be forgotten that the *cure* of disease is not that to which the family practitioner is called. His business is to *guide* the patient through the quicksands of disease. Like the soldier, his duty is not to conquer, but to fight, to fight wisely; to fight victoriously if may be; but, even in retreat, to keep his face to the foe and dispute every inch of ground, seeking to snatch victory from the jaws of defeat. I have no sympathy with the physician who quits his patient with the statement that he can do no more for him. His duty is to stand by the patient to the end, seeking the advice of wiser men if he can obtain their aid. The doctor who has no remedies to soothe the distress of hopeless or dying patients is unworthy the name of physician. Nor do I sympathize with those who in chronic or apparently incurable cases send the patient away with instructions to "go home and take no further advice or medicine, as the case is beyond the aid of remedies." This may be science, but it is not medicine. In the first place the patient will not desist from the attempt to secure relief; and, secondly, the doctor's business is to search out a remedy, never ceasing in his endeavor as long as the patient looks to him for aid. Tireless effort on the part of a physician of little repute will sometimes lead to success, when brighter minds have judged the quest hopeless. Many a family physician owes his success in building up a practice to just such dogged perseverance on behalf of patients deserted by other doctors. And many a valuable remedy has been found by just such efforts. In fact, the apparently hopeless cases are just the material for the development of therapeutic ability.

Finally, the skillful therapist of the future will be expert in dealing with that "third something" which is "neither matter nor force nor a modification of either," which is variously called in philosophy the consciousness, the life, the spirit, the soul. That element which embraces the emotions, the will, the character, the intellect, the judgment. If the physician lacks the ability to understand and to control this element, drug therapeutics will lose half its efficiency. Materialism may fill the needs of science; but medicine includes more than materialism, and must aspire to comprehend, to guide and to heal the disorders of the unseen immaterial element in man. And so drug therapeutics rises to the level of the noblest callings to which man can attain. Guided by wisdom, tact and loving sympathy, the bedside administration of pharmaceutical remedies wields an incalculable power for good and offers possibilities for development of its beneficent influences which are simply beyond compute.

889 Park Avenue.

### MY FIRST AMPUTATION AFTER LEAVING COLLEGE, AND SHORT HISTORY OF A CASE.\*

BY W. D. BUSH, M. D.,  
OF PROVIDENCE, FLORIDA.

After graduating at the Baltimore Medical College, I returned to my southern home in Florida. In a short time I was called to see a man that had lost part of his foot and seemed to be exceedingly anxious to lose more.

His history is: Age, 48 years; occupation, laborer. General health previous to two years past, good. Family history



very good; had a sister to die with something similar to his disease, but much worse, chronic gangrene.

He had his foot cut on plantar surface several months previous to his last trouble; this seemed to unite with perfect union. In March, 1893, he was working in a well and was standing on the toes of his foot that had been cut, something gave way in his foot and he had a sickening sensation and had to be taken out of the well; in a short time after this he was taken with severe pain in his great toe; it extended up, and his whole foot was soon involved. Circulation stopped, foot became cold, and in a short time began to slough on plantar and dorsal surfaces; line of demarcation formed about tarso-metatarsal articulation. All anterior to this sloughed off. I did not see him until three months after he was taken; ends of the bones were exposed and necrosed. It was a case of gangrene from some cause; may have been due to thrombus embolism or erysipelas. I believe his physician treated it for erysipelas.

It is said two physicians saw his foot and advised him not to have it amputated; he sent for a third, but he did not come; they all seemed to think if an amputation was done he would die. This man had tried nature for three months, and she could not accomplish a cure, so he wanted an amputation. I was sent for, I went and examined his foot and advised an amputation, to which he readily agreed. So on the 28th of June his regular family physician (Dr. Neusom), Dr. Niblack and a medical student, Mr. Clyatt, and myself went and amputated his foot, doing a circular operation at lower third of leg. We could not do

Chopart's operation, as flaps were too short; they were not solid enough for an amputation in ankle joint, so we decided on a circular at lower third. No bad indications showed up during the operation. Tried to do a clean operation and used antiseptic dressing. Stump was perfectly dry when dressed, but in a short time began to ooze; did not redress until next morning, when I put on a new antiseptic dressing and used all precautions. I saw my patient every other day for one week; he did not have fever, inflammation, or pus formation; put him on iron and quinine. He was a physical wreck, so we did not wait for bad indications. He began to improve at once, and to-day he is up and doing well.

For my surgical knowledge I must thank the professors in the University of Virginia and of the Baltimore Medical College.

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### Society Reports.

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#### ANNE ARUNDEL COUNTY MEDICAL SOCIETY.

The Anne Arundel County Medical Society met at 11 A. M., Tuesday, Sept. 5th, in the parlor of the Maryland Hotel, Annapolis. In the absence of the President, Dr. Anderson, the Vice-President, Dr. Geo. Wells, presided, with Dr. B. R. Davidson, Recording Secretary.

No formal papers were presented. A discussion of the prevention and treatment of diphtheria took place, four cases of this much dreaded malady having recently appeared here.

Several members also related interest-

ing cases which had happened in their practice since the last meeting of the Society.

The Society, after a very short session, adjourned, to meet in special session on the first Tuesday in October, and it is earnestly hoped that a larger attendance of members may then be had.

CHAS. B. HENKEL, M. D.,  
Corresponding Sec'y.

#### THE LESSON OF OUR MATERNITIES

Writing in the *Medical and Surgical Reporter*, September 9, Dr. Price remarks: We have long since proven that maternal deaths are avoidable, deaths not only from sepsis or child-bed fever, but from other causes as well; death in child-bed means an error of omission or commission. The mortality in maternity hospitals is now the lowest. Maternities have settled about all the important disputed points in obstetrical practice. The most perfect work has been done in the maternities of Baltimore, Philadelphia, New York and Boston. Not only has this work been perfect from the standpoint of a low mortality, but the hospitals in which it has been done have done a great work in practical teaching, demonstrating beautifully two points: 1. That a maternity can be run with a nil mortality. 2. That it can unite with its humane purpose practical teaching with a nil mortality. All this has been disputed both at home and abroad. The time is not distant in the future when the directors of maternity hospitals will not dare to appoint a man to direct or have official charge of such vital interests without a rich practical experience and sound judgment.

They will be held responsible for the success of their trust, and it is to be hoped will be held criminally responsible for the choice of a person to such trust with no more pride of personal cleanliness and cleanliness of environment than a stable boy, dirty in all the term implies, morally and personally.

#### SYPHILITIC INSANITY.

In a recent address, Dr. Mills (*American Lancet*, September) says of this disorder: It may be necessary sometimes to separate a form of *juvenile dementia the result of inherited syphilis* from idiocy and imbecility, whether of syphilitic or other origin—which may commonly be done by the fact that the dementia usually comes on after the child is four or five years old, and therefore when the mental condition has been determined not to have been that of idiocy. In rare cases it happens that a juvenile or infantile dementia occurs when the child is two or three years old, so young that its true mental status has not been fully determined. With this word of caution as to the possibility of inherited syphilis showing itself in a child otherwise healthy in the first year or two of its life, most of the cases of this form of dementia will be comparatively easy of recognition. A family history of syphilis will often but not always be obtained. Often the upper incisors will be pegged and notched, and cicatrices at the angles of the mouth, and the characteristic physiognomy be present; the child will have attacks of keratitis, choroiditis, or iritis, or a history of snuffles, or of a rash; and sometimes epilepsy will have developed.

## MARYLAND MEDICAL JOURNAL,

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A. K. BOND, M. D., Editor.

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BALTIMORE, SEPTEMBER 23, 1893.

**Editorial.****A REFUGE IN THE SEA.**

Where lies the tragedy of life? Not in the patient endurance by healthy men and women of poverty and grief; not in the winning conflict which the well-nurtured body wages against evanescent disease; but in the almost hopeless, steadily failing struggle which a mind diseased from birth and depraved by ancestral taint wages against an overpowering thirst for drink; in this we find the awful tragedy of life.

Upon the lunatic shut up against his will by force of law in an asylum where he may, if curable, be skilfully restored to sanity; or if hopelessly deranged, be tended and guarded by gentle sympathy; we gaze with sadness, yet with sadness almost obscured by gratitude to the Teacher of Nazareth, who through the ages still calls men to loving thoughtfulness for the helpless and afflicted. But from the contemplation of the struggles

of men or women cursed with the thirst for drink, whose pride or whose domestic burdens will not allow them to seek refuge in a hospital, and who are daily and hourly, in the pursuit of the means of support, exposed to subtle temptation from the allurements of the saloon or the solicitations of acquaintances; whose efforts after freedom grow ever feebler as the conscience becomes blunted by indulgence and the intellect benumbed by alcoholic poisoning, while the nervous tissue of the great centres cries out incessantly for renewed stimulus; from such a view we turn away with inexpressible horror and raise our hands to heaven in mute appeal for help.

Day by day in every family connection of the land (almost without exception as far as we may judge) this struggle is going on. Some of the strugglers find help in home influence, some in medical care, some in the revolt of an outraged self-respect, some in the stimulus of religious life; but by many, nay, by thousands, these sources of succor are spurned or but half tested, and the issue of the struggle is in hopeless loss of every faculty that makes for the nobility of man.

This is no over-drawn picture; and by none will its truthfulness be more readily admitted than by the family practitioner, who has to listen in helpless silence to the appeal for relief which comes from wife and parent and child. And often, after answering such an appeal with words of empty comfort, does his thought reach forward to the centuries that are to come, in wonder whether the genius of scientific men, or the sympathy of the philanthropist, or the wisdom of the legislator, will ever find a remedy which can actually and universally be applied,



Will the stigma of asylum-refuge ever be lessened, will the State ever assume the right to commit chronic drunkards for treatment, will the use of alcohol ever be honestly limited by law, will the instruction of children in "physiology" appreciably lessen the number of inebriates in the community?

After such reflections we turn with patience, even if not with confidence, to the proposal of Dr. Peterson, Professor of Nervous Diseases in the University of Vermont, who at the conclusion of a paper on the treatment of alcoholic inebriety, in the *Journal of the Amer. Med. Assn.*, April 15, suggests that an attempt be made to establish on some island of our sea coast a refuge for those afflicted with the vice or disease of alcoholism.

Here that protection from temptation to drink, which it seems impossible to secure in existing centres of population; which a few of the rich obtain in inebriate hospitals, and many of the poor, when reduced by drink to hopeless destitution and disease, find in the almshouses; may be afforded to all who wish it or who are known to need it.

Here, in an invigorating climate, communities devoted to the pursuit of agriculture, of manufacture and of commerce, might be built up by those who possess every faculty necessary for happy, successful life, save the power to refrain from drink. Hither the mechanic or the professional man cursed with the drink-thirst might remove with his family and gain new life and hope.

The plan seems feasible; who will put it to the test of actual experiment?

Dr. Oliver Wendell Holmes passed his 84th birthday in good health on Aug. 29.

## THE MEANING OF ALBUMINURIA.

When the association of persistent albuminuria with chronic disease of the kidney was first made out, physicians were prone to hang the tombstone "Bright's disease" about the neck of every unfortunate patient in whose urine albumen was found. More mature experience proved that there are grades of albuminuria, of various severity and persistence, and that the prognosis must include a number of conditions other than the mere presence of albumen. Now even the life insurance companies are beginning to doubt whether the simple detection of albumen in an applicant's urine ought to be sufficient ground for refusal of insurance.

An accurate forecast, therefore, of the issue of a case of albuminuria is a much more difficult matter than was formerly supposed. In fact, the whole subject of nephritis is still in a somewhat chaotic state, different writers giving quite irreconcilable classifications and explanations of the various symptoms of kidney disease.

In an instructive clinical lecture reported in a recent exchange, Dr. H. C. Wood, of the University of Pennsylvania, discusses the "Mystery of the Development and the Secret of Prevention of Contracted Kidney," and draws several striking lessons from the consideration of cases which have arisen in his practice, which lessons we may epitomize as follows:

The kidney, like the lungs and certain other organs, is subject to attacks of catarrhal inflammation. And, as recurring pulmonic catarrhs may, if not rightly treated, lead to grave and incurable disease of the lung tissue, so repeated attacks of nephritic catarrh, the

index of which is albuminuria, may if undetected or neglected end in deep-seated and fatal chronic disease of the kidney substance.

The physician, therefore, who would be a faithful guardian of his patients' lives and health, must in all suspicious disorders examine the kidney secretion for signs of catarrhal inflammation, viz.; for albumen and casts; and if they are found, must remove all known causative conditions and put the parts into as restful a state as possible. The urinary examination must be repeatedly made, as albumen may be present at one time and absent shortly afterwards.

The causes which induce albuminuria in sensitive kidneys are mineral poisons, as arsenic, lead, alcohol, etc., brought into the body from without; and likewise various substances elaborated within the body, as oxalic acid, uric acid, and probably ptomaines and kindred compounds. Nervous shocks, heat exhaustion, etc., may perhaps cause albuminuria by checking digestion and so throwing the above-mentioned substances into the blood. These passing attacks of kidney catarrh must receive prompt attention, but must not be mistaken for deep-seated chronic disease.

### Medical Progress.

#### THE BLOOD IN MELANCHOLIA.

Dr. W. Steele (*Amer. Jour. of Insanity*) says:

From a study of these cases [twelve in number], we are, I think, warranted in forming the following conclusions:

That in melancholia, both acute and chronic, there is a very marked deficiency

in the number of hæmocytes, in very few cases the percentage even approaching to the normal; and that the percentage of hæmoglobin is reduced in like proportion.

That in a number of cases showing considerable crenation of the hæmocytes at first they are found to be much less created after tonic treatment and the mental improvement following it.

That systematic tonic treatment is found markedly efficacious in the treatment of this form of mental disorder. The administration of iron by itself, or a combination of iron, quinine, and strychnia, seems equally effective. It would appear also that, although melancholia may not be caused by an impoverishment of the blood *per se*, such impoverishment almost invariably exists, and in a large majority of cases improvement of the mental symptoms is coincident with improvement in the general health and in the quality of the blood.—*Ex.*

#### SIGNIFICANCE OF MURMURS.

The editor of the *Northwestern Lancet*, June 1, writes thus concerning this important topic:

Dividing all murmurs into the valvular and non-valvular, it becomes very important to be able to distinguish with certainty between the two, and to pick out from the non-valvular murmurs those that are functional. Much has been said about the difference in the sound of murmurs as showing their character, that the [anæmic and functional murmurs are] soft and blowing, systolic in character and not transmitted through to the back. This is true in general, but unfortunately the converse of it is not; there are functional murmurs that are not soft and blowing, but

loud and harsh, that are transmitted all over the chest and that are diastolic and not systolic. On the other hand, serious valvular lesions may be accompanied only by a faint, soft, systolic murmur, not transmitted. Of the other non-valvular murmurs those due to pericardial adhesions can rarely be diagnosed unless the adhesions are such as to retract the chest wall, although it may often be strongly suspected that a murmur is extra-cardiac. There is nothing characteristic about the sounds produced by clots within the heart or aneurismal dilatations, and when any of these lesions coexist with dropsy from other causes, such as nephritis, with perhaps shortness of breath and cardiac enlargement, the diagnosis becomes very difficult, if not impossible.

The text-books are rather misleading about the diagnosis of valvular lesions. The fact is that auscultation alone cannot be depended upon. The whole clinical picture must be taken into account before a safe conclusion can be arrived at. In the first place the history of some antecedent disease that is likely to be followed by a cardiac lesion should be an important factor in the diagnosis where physical signs are wanting other than a murmur. The vast majority of cases of valvular disease of the heart follow acute rheumatism or some other infectious disease, such as diphtheria or scarlet fever. It is decidedly the exception to meet with heart disease that has not been preceded by one of these maladies. The original disease may have occurred long before the heart trouble shows itself by general symptoms, for during youth and early adult life a crippled heart will often adapt itself to

the work it has to do. But after middle life is passed the organ begins to give out, and the patient when he finds out what is the matter often believes himself to be suffering from a recent heart trouble, not dreaming that the disease has been there since his childhood.

Dropsy, shortness of breath, congestion of the liver and kidneys, almost always go with enlargement of the heart, and give very positive evidence of a valvular lesion. But until these general symptoms appear it is really impossible to make a positive diagnosis of cardiac disease, that it is of a valvular lesion. The patient should always be given the benefit of the doubt, and without being frightened should be told of the suspicion and cautioned to avoid violent exertion. That is, some patients should be told; for there are others to whom the words heart disease would be a death blow, and who would be so miserable from the suspicion of such a thing that it would be better to let them take their chances rather than to utterly take away their peace of mind. Cases have often been watched for years where most tremendous murmurs have existed with no harm to the individual, who has gone along entirely ignorant of the possibility of danger from such a source. There are few situations where there is opportunity for the medical practitioner to make better use of judgment than in the management of cases of heart murmur unaccompanied by other physical signs.

#### STERCOREMIA.

There is a very interesting paper on "Constipation," by Dr. Skinner, in the *Amer. Pract. and News*, June 3. In the discussion of it before the Louisville



Medico-Chirurgical Society, Dr. Larrabee said:

Regulating the system and keeping the bowels in a soluble condition cannot be overestimated, and I am one of those who believe in the poisonous effects of retained material in the bowels. If we have a disease called "uremia" from retention of the urine, I do not see why we cannot have diseases dependent upon "stercoremia." Many people may have died from causes produced entirely by constipation.

There is one point which has struck me all along while engaged in the practice of medicine, and that is the success of quacks who use nothing else than aloin purificata in the treatment of chronic diseases. You can take it for granted that when a man starts out with patent medicines, medicines which he himself has patented and advertises for the cure of chronic diseases, that he is giving aloetic purgatives; and another fact, that is not sufficiently weighed by physicians in debarring the quack, is that he succeeds in relieving many of these chronic cases. Any old chronic case of anything, I do not care what it is, whether rheumatism, gout, or whatever it may be, is more or less relieved by a severe purging. That is where the quacks get in their work; they help every case of that nature, old patients, men who have been drinking a good deal. I know of half a dozen cases here where old chronic cases of mine have bought medicines from men who were selling them along the street, the vilest compound ever put up, a decoction of aloes, and horse aloes at that, and every one of them were relieved, and relieved for quite a while.

#### FOR LATERAL CURVATURE OF THE SPINE.

The most important element in the treatment of this affection is the development of the weakened muscles and the correction of the lateral deformity. This can be accomplished by self-suspension and free movements. Self-suspension may be practised at home in the same way as the patient has just done here when we were illustrating the method. Both hands may be placed one upon the other at the same plane, or one may grasp the rope above the other. One of the best methods is to grasp the rope higher with the hand of the side of dorsal concavity—as, in the case mentioned, the left hand above the right. For the same purpose a double-bar trapeze may be employed, the left hand being placed above the upper bar, and the right upon the lower bar. Of the free movements, the Swedish are among the best. Of these the "keynote" position is an excellent one. In this the patient, standing erect, with the heels together, raises both arms from the sides upward and outward, until the right arm is brought to a horizontal position and the left (assuming, of course, that this is the side of dorsal concavity) reaches a vertical position, in both with the elbows stiff. This position is quickly taken, held for a few moments, and the arms slowly dropped to the sides. This is to be repeated from fifteen to twenty times twice daily. In small children a variety of exercises may be taken, so as to keep up the interest and make the exercises attractive.

The curve itself may be best corrected by means of a broad leather strap attached at both ends to the wall. The

middle of the hand is placed over the prominence, and, placing the feet together, by throwing the weight of the body against the strap the curve is directly pressed upon and forced into a more normal position.

The object in all of the exercises is to develop the weak side and to avoid as long as possible the use of confining apparatus. These produce atrophy, and are only to be employed when the deformity is rapidly growing worse. The exercises are to be pursued for a long period; it must be a steady course of long duration. If these fail, and the deformity increases rapidly, apply some fixed apparatus that will assist the weakened muscles to maintain the body in its erect position. This may be made of steel; or a stiff leather jacket may be employed. At home the child can have a simple horizontal bar on which he may swing by his hands. He may also use dumb-bells and clubs. A very valuable position is what may be called the "turtle position." The patient lies prone upon the face, with the arms extended, and with the head carried upward and backward as far as possible. This exercises strongly the muscles of the upper part of the spine and back of the neck.

—Dr. Willard, *American Lancet*.

#### PARALYSIS AGITANS.

In closing an elaborate article upon this disease, Dr. Dana (*New York Medical Journal*, June 10) speaks thus of its treatment: After so much that is purely scientific, and perhaps purely hypothetical, I ought perhaps to say a word that may be interpreted as having a practical bearing upon the therapeutics of the disease. Paralysis agitans seems to me

to be a disease whose progress at least we ought to stop, and which, in its early stages, we ought to cure. It is indeed with a feeling of humiliation that I watch the steadily downward progress of this painful malady in so many cases. There is no serious anatomical change at the basis of this trouble, such as we find in chronic myelitis, or in tumors, or even in locomotor ataxia. There is nothing which makes it intrinsically improbable or impossible that we should cure this dire and painful malady. When we reflect upon the enormous achievements of the human intellect in other fields in erecting extraordinary specimens of engineering skill, in unfolding the wonderful powers of electricity, in organizing industry, and subduing every force of nature to our use and making them tend toward the increase of our comfort, the enlargement of our knowledge, and the greatness of our civilization, it does seem pitiable that so small a problem as that of stopping the course of this apparently insignificant disease should be still unsolved. Is it because great and ingenious minds are not found in medicine but are lured away by the fascinations of statecraft or the prizes of commerce? The line of inquiry of research should be, I think, pursued most diligently, most indefatigably, in this direction. If I am at all right in my theories of the disease, we must find some kind of antitoxine which will counteract the poison which circulates in the nervous centres, or we must, through some agent, stop this disordered action by which this poison is thrown into the system. Whether this can be done through any animal extracts, as has been done

successfully with a still more serious malady as myxœdema, I do not know. In one typical case I had injections of brain juice made daily for a period of three weeks, but without any results whatever. While experimenting in this direction we must, of course, follow out as much as we can the symptomatic indications. These would lead us, for one thing, to order, as we all do, rest in the treatment of this disease. This is always indicated in irritative and inflammatory processes, and its usefulness in shaking palsy is acknowledged. After rest, I think it will be admitted that opium helps us most. Whether this is by dulling the sensory centers or by interfering with metabolic action or glandular activity, I can not say. I have found that the use of salicylate of sodium and of salol often secures excellent results, and this, too, I could only explain on the theory of some toxic substance or some diathetic poison being at the root of the symptoms.

Among the ancient remedies which were recommended in the disease is iron, and the fact which my examinations show, that in the latter stages a chlorosis develops, would lead us to employ this in conjunction with arsenic. The older recommendations regarding severe counter-irritation to the spinal cord might perhaps be wisely utilized in connection with our present knowledge of its pathology. I have myself seen good results follow from the application of counter-irritation to the spinal cord. Of other remedies—such as hyoscine, eserine, strychnine, lukewarm baths—it is not necessary for me to speak. We are all familiar with their results and their disappointments.

#### ACUTE ULCERATIVE ENDOCARDITIS.

Writing upon this theme in the *Jour. Amer. Med. Assn.*, June 10, Dr. Hektoen makes the following summary of etiological and pathological facts:

1. The disease is caused by the localization of microbes in the blood upon the endocardium. The streptococcus pyogenes, the micrococcus lanceolatus (pneumococcus), the staphylococcus pyogenes are found most frequently and in the order named. Various other microbes have been found also, such as the pus microbes, the bacterium coli commune, the gonococcus, the bacillus typhosus, as well as bacteria that have not been found in other diseases and are in so far as yet peculiar to malignant endocarditis. Recently the bacillus diphtheriæ was found in the endocardial lesion (Howard, *J. Hopk. Hqs. Bull.*, April, 1893). Experimentally the disease can be produced by first causing some mechanical or chemical injury to the valvular endocardium and subsequently injecting cultures of various bacteria in the blood, or by intravenous injections of cultures of staphylococcus pyogenes aureus on potato suspended in water with scrapings from the potato when the micrococcus agglomerations attach themselves to the endocardium more readily than the single cocci (Rosenbach, Wyssokowitch, Weichselbaum, Prudden, Fränkel and Sängner, Netter, Gerarieu, Ribbert).

2. Acute ulcerative endocarditis is met with as a secondary lesion in the acute infectious diseases, notably and most frequently pneumonia, also in meningitis, acute articular rheumatism, the specific fevers, gonorrhœa, dysentery and so on. It is frequently incorporated into sup-



purative, septic and pyæmic processes. Finally it may occur as a primary or cryptogenetic affection, developing without any known or demonstrable infection atrium. From the mycotic endocardial foci microbes and infected fragments may be carried away by the blood current and give rise to embolism in the various parts of the body, local necroses, and secondary pus accumulations.

3. In over one-half of the cases (three-fourths according to Osler), the acute ulceration is implanted on an old valvular lesion, the absence of endothelium and the roughness presenting assailable points for microbial invasion. This is the only competent reason for the occurrence of an overwhelming majority of the instances in the left heart, but the explanation is not complete, because of the cases affecting primarily healthy valves, over two-thirds occur in the left side and about one-third in the right half.

#### ACID FOR CHOLERA.

In the *Jour. Amer. Med. Assoc.*, April 15th, Dr. Cheney presents some remarks which may prove of interest to our readers in case choleraic diarrhœas become prevalent among us. He says:

The cholera, like nearly all the other choleraic diseases, is a most dangerous and deceitful disease. In the first place, it cheats its victims by the decided luxury of the early diarrhœa and therefore puts the person off his guard. In the second place, it does its work all too often in the interior by draining the watery portion of the blood into the bowels without its appearance externally. The often mysterious and sudden cases are largely of this kind, the copious ex-

ternal flood coming down later in the disease, or on relaxation of the sphincter at death. In both these respects the public should be informed, that proper aid may be early sought.

To these points for the people, I want to add the most emphatic of all for the profession—that the true choleraic discharges are *alkaline*, while those of cholera infantum are mostly *acid*. Therefore the alkaline treatment of the latter, particularly by the hyposulphite of soda, is in the line of success, while the acid treatment, particularly by the sulphuric acid, is the proper treatment for the Asiatic cholera, since the choleraic microbes do not flourish in acid liquids, while they do in alkaline, the acid preventing their development and work. This is the most practical fact which the whole science of the cholera has yet developed. For while opium, empirically, is serviceable in checking the early diarrhœa, the fixed mineral acids practically beard the wolfish microbes in their den. And certainly no other one treatment has developed so much in its favor as the acid. That it has done so no more, is because it has not been wisely administered and properly trusted.

So far as I have had experience in the use of acid in choleraic diarrhœa, I have been highly pleased with the results. But my purpose in this writing is to show some cards I have in my hands.

Pettenkofer noted the alkalinity of choleraic dejections, and states that safety lies in preventing the ammoniacal change in the urine and fæces, and that the agents which will accomplish this are the mineral salts, the mineral and carboic acids. The excrements may therefore always be rendered innocuous

and conveyed away from the vicinity of human dwellings while still in an acid and harmless state.

Dr. W. I Cox, of Kensal Town, was the first to use the sulphuric acid in cholera in England. Through the aid of Dr. Herepath, of Bristol, England, he made the discovery that a celebrated Austrian remedy consisted chiefly of sulphuric acid.

Dr. S. T. Chandler, of Kentucky, having had experience in the epidemics of 1854 and 1873, in the use of the acid, states that it "relieves the nausea, arrests the vomiting like a charm, and gradually the dejections are stopped."

Dr. McClellan confirms the value of the acid treatment, and gives it the credit of reducing the cholera mortality to 8 per cent., while the lowest by other means is 23 per cent. and from that up to 59.

Dr. John M. Woodworth, supervising surgeon U. S. Marine-Hospital Service, said: "Beginning with the year 1814, the cholera literature down to the present time abounds in proofs, clinical, physiological and metrollogical, of the efficacy of sulphuric acid."

Bristowe, Aitken and others express a disbelief in the power of medicines to cut the cases of cholera short, yet they make no reference to the mineral acid treatment. The writer is sure that the cholerine and the early stages of the cholera proper will almost certainly yield promptly to the acids alone, or to them in connection with small doses of laudanum.

"My own conviction is," says Dr. Fuller, who had large experience with the use of sulphuric acid, "that in sulphuric acid we have an antidote—a spe-

cific—against choleraic diarrhœa, if not against the worst forms of cholera, as powerful and energetic, and as certain in its effects, as cinchona bark or quinia against a paroxysm of ague."

From these cases, however, must be excluded the bilious and chronic diarrhœas. Fuller is emphatic in saying that "in epidemic diarrhœa, in acute autumnal diarrhœa, I have known no single instance of its failure; indeed, the more choleraic the diarrhœa the more speedily are its curative effects produced.

The dosage of acid needed is 3ss of dilute sulphuric acid well diluted with water and given every twenty or even every ten minutes according to the severity of the case. If the first dose is rejected another should be given immediately. If retained the drinks of the acid water may be more and more copiously given to flush out the intestinal tract.

Wherever the cholera gains a foothold all alkaline and fermentable fluids should be discarded, and lightly acidulated drinks used. Weak aromatic sulphuric acidade, carefully prepared and taken through a glass tube, would be very pleasant, refreshing and wholly harmless. Such drinks might be substituted for the soda fountain by the apothecaries to profit and advantage, a glass two or three times a day being a good prophylactic.

#### THE EYE-DEFECTS OF SCHOOL CHILDREN.

An instructive article upon the care of children's eyes is given by Dr. E. O. Belt, formerly of Baltimore, now of Washington, in the September number of *Food*. In it he says:

Astigmatism, near-sightedness or far-



sightedness may not be noticed for some time after a child has begun school. Their hatred of books may be attributed to indolence, their backwardness in studies to dulness, and their headaches and nervousness to general weakness; when their eyes may be the cause of it all. Crusty lids, loss of lashes, frowning, painful eyes and browaches are very common indications of far-sightedness, or astigmatism, which should be relieved by proper glasses. Under eight years of age teaching of children should be mainly by object lessons; they should not be permitted to study more than a few hours a day, and none at night. The print of their text-books should be large, and the school-rooms well lighted. These rules should apply especially to children whose parents are near-sighted, for they will inherit that tendency.

Near-sighted children being cut off from many outdoor sports by defective vision, find most pleasure from books, and besides their studies will often be seen poring over poorly printed novels, during recess and in the evenings by twilight and bad lamp light, thereby increasing the defect which is already isolating them from their school-mates, and unfitting them for many vocations in life. The way these troubles develop, if not attended to, is shown by the following report of an investigation I have recently made among pupils in the public schools of this city. . . .

By numerous examinations made in the schools of this country and of Europe, it has been found that comparatively few children are near-sighted when they first begin school, but at the end of school life a large percentage have this defect.

### Recommendations of Therapeutic Agents.

#### LISTER'S RENEWED ALLEGIANCE TO CARBOLIC ACID.

It is not surprising to those who have kept pace with the progress of antiseptics to hear Sir Joseph Lister, after twenty years of investigation and experiment, declare his renewed allegiance to carbolic acid, as he did in a lecture January, 1893 at Kings College Hospital in London (*Annals of Surgery*, June, 1893.

Carbolic acid is not only a more efficient surgical germicide than corrosive sublimate, but it is much more efficient in cleansing the skin. It has a powerful affinity for the epidermis, penetrating deeply into its substances, and it mingles with fatty materials in any proportion. Corrosive sublimate on the other hand cannot penetrate in the slightest degree into anything greasy; whence those who use it require elaborate precautions in the way of cleansing the skin. All of this is unnecessary with carbolic lotion. Sir Joseph does not even use soap and water, trusting entirely to the carbolic acid.

There is a new product of phenol and boracic acid, in which has been mitigated the pungency of carbolic acid, disguising its odor, and greatly supplemented its efficiency by its combination with boracic acid, which, although admittedly slower in its action, is nevertheless unsurpassed as a true germicide.

For appendicitis, if seen early, give absolute rest, fomentations, salines every half hour until four or six fluid stools are produced.—*Ex.*



**Medical Items.**

Dr. Chas. E. Simmons has settled his claim for medical services to the late Samuel J. Tilden for \$40,000. The claim was for 143,350.

Dr. Willis King says that during his boyhood three animals were known by the odor: a billy-goat, a skunk and a doctor.

To excite respiration in a baby which does not cry immediately after birth, hold it up by the feet and spank it. Wrap a cloth about the feet to keep them from slipping.

It is reported that Dr. Henry W. Williams, the ophthalmologist, has announced his intention of giving the sum of \$25,000 for the endowment of a professorship of ophthalmology at Harvard University.—*Lancet-Clinic*.

A recent decision of the New York Court of Appeals says that when a physician accepts part payment of a bill on condition that this settles the case, he is prevented from collecting the rest of the bill later. This is contrary to what holds in ordinary accounts.—*Amer. Lancet*.

The Health Department of New York City has paid \$960 for a portable disinfecting machine. It is drawn by horses and can be taken in front of an infected house to disinfect clothing, bedding, etc. The invention is of Hamburg origin, where it was used effectively during the recent epidemic.

Dr. Brown-Sequard again calls attention to the fact that occasional pruritus

ani depends upon drinking coffee, and publishes a case in which leaving off the beverage completely cured a case, the malady returning on recommencing the beverage.—*Cin. Lancet-Clinic*.

A study of the effects of removing the ovaries shows that for some time there are menstrual molimina and the ordinary signs of the climacteric appear. The deposit of fat in the abdominal walls, buttocks and other parts of the body is attributed not to excess of nutrition but to vaso-motor changes. When the uterus is removed and the ovaries left behind the latter do not atrophy, as has been claimed, but subsequent autopsies have shown them unchanged in size and containing Graafian follicles ripening or breaking.

Rectal feeding may be carried on by means of a mixture of two eggs, twenty grains of pepsin, ten grains of chloride of sodium, and six ounces of water (*Detroit Emergency Hospital Report*). This mixture should be slightly warmed, thoroughly agitated, and then gently introduced into the bowels by means of a syringe. To facilitate the entrance of the fluid into the intestines, it is well to put the patient in a position with the hips much elevated above the head; either the knee-chest position, or with two or three pillows beneath the hips.—*Canada Lancet*.

Dr. E. Holland calls attention to the fact that the taste of chloral hydrate is effectively masked by lemonade. Two or three drams of the syrup should be placed in a tumbler with about two ounces of water. If to this is added about two ounces or so of gaseous (bottled) lemonade,

the mixture may be drunk at leisure, and the soporific action of the drug is in no way impaired.—*London Practitioner*.

Incontinentia urinæ, when due to slight disorders of genito-urinary or nervous systems, may be relieved by rhus aromatica, beginning with five to ten drops and increasing to fifteen or twenty, four times daily.—*Medical Record*.

Dr. L. F. Raynaud, of New Orleans, has been appointed Professor of Materia Medica and Therapeutics in the Medical Department of Tulane University, of Louisiana. Dr. A. B. Miles has been transferred from that chair to the chair of Surgery.

A traveling medicine company came into Clearfield County not long ago and stocked the county up with its cureall. Then the company set about to get certificates of its healing powers. One man, who received \$5 for his interest in testifying to the merits of the medicine, had his picture printed in a book of testimonials over his signature, and with a story saying he was a sound and well man from the use of the medicine. Some kind neighbor found the picture and certificate as printed, and, being of a public spirit, sent it to the pension commissioner at Washington in the hope of saving the government some money. In a few days the man who had certified to his excellent physical condition and perfect health received notification from the pension office that his name, which had previously been good for a quarterly stipend, had been dropped from the rolls.—*Ex*.

The filthy water of the River Nethe is purified for use in Antwerp by being passed through revolving cylinders con-

taining small pieces of iron. Fifteen pounds of metallic iron will purify 1,000,000 gallons of water. The water thus treated is said to be completely freed from germs, bacteria and other objectionable matters. English and French chemists find that the contact with iron reduces the organic matter by from 45 to 85 per cent., and albuminoid ammonia by from 50 to 90 per cent., and all free ammonia is removed. The process has been applied with success to the water of the Delaware River in Pennsylvania. It is simple and cheap. From all of which it may be inferred that the passage of drinking water through iron pipes does not injure it.—*Ex*.

The following rules, with these exceptions, were formulated by Professor G. A. Wiggins: 1. The dose of all infusions is one to two ounces, except infusion of digitalis, which is two to four drachms. 2. All poisonous tinctures, five to twenty minims, except tincture of aconite, which is one to five minims. 3. All wines, from one-half to one fluid drachm, except wine of opium, which is five to fifteen minims. 4. All poisonous solid extracts, one-half grain, except calabar bean, which is one-sixteenth to one-fourth grain. 5. All dilute acids, five to twenty minims, except dilute hydrocyanic acid, which is two to eight minims. 6. All aquæ, from one to two ounces, except aqua lauro-erasi and aqua ammoniæ, the dose of which is ten to thirty minims. 7. All medicated syrups, one drachm. 8. All mixtures, one-half to one fluid ounce. 9. All spirits, one-half to one fluid drachm. 10. All essential oils, one to five minims.—*Pharmaceutical Record*.

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## Original Articles.

### A SUMMER'S EXPERIENCE IN THE MOUNTAINS OF VIR- GINIA.\*

BY EUGENE F. CORDELL, M. D.,

Professor of Principles and Practice of Medicine,  
Woman's Medical College of Baltimore.

On the morning of the 4th of last July I took the train for the mountains of Virginia, where I had been invited to take the position of Resident Physician to one of the many springs of that great region of summer resorts. The weather was warm and I was glad to get away from the city, and the prospects before me were of the most encouraging character. I enjoyed the ride and scenery of varied woodland, fields dotted with stacks of newly cut wheat and glimpses of distant river and mountains.

After leaving the station, we had a delightful ride of 13 miles across the country, reaching the springs in time for late tea. The springs were situated at the base of a long range of mountains which form the northern boundary of a wide valley, famous for its fertility and its beautiful scenery. Just before reaching our destination we ascended a zigzag road to the top of a high hill known as Suttentick Ridge, where all at once the towering mountains opposite burst upon our admiring view and far below us we saw a meandering stream and caught a glimpse of the half-hidden buildings of ———. A precipitous descent by S-shaped curves soon brought us to our destination and with a crack of the driver's whip we made a dashing and triumphant entry into the grounds. The next day I took posses-

\*Read before the Medical Society of the College during the session 1892-'93. (Only extracts from the paper are published.)



sion of my permanent quarters, which consisted of a reception and private consultation room and bed-room near by. I soon had my box of drugs unpacked and my materia medica displayed upon shelves, and had the satisfaction of being told that no previous resident had had so varied and complete an assortment as I. I had provided myself with everything likely to be needed for any ordinary examination and treatment, but had little opportunity of making use of apparatus of any kind. There was but one occasion for making a microscopical examination of urine, and I did not wash out a single stomach (the new fad). But one patient himself prescribed for electrical treatment, and he a physician and old hemiplegic, for whom there was prospect of neither fee nor benefit; so that my costly chloride of silver battery which I had brought with such care and had scarcely allowed to be off my lap during my trip and from which I had expected so much, added nothing to my income. The most prevalent disorder which I was called upon to treat was derangement of the stomach and bowels. The water, which is of the purgative iron class, containing the sulphates of iron and magnesia and free sulphuric acid as its chief ingredients, may have been responsible for some portion of this disturbance, but I am certain that it was far oftener referable to imprudences in eating and especially to the character of the food. People at summer resorts, having nothing to do, yield readily to the promptings of their appetites and eat far more than their stomachs can digest. In our case there were special circumstances, I think, at the bottom of the trouble. The season being late in the mountains

and the supply at best limited, we had to draw our vegetables from the city markets, and often these articles had been brought from the south and were doubtless stale when we received them. I drank no water and yet I had an attack of inflammation of the bowels, which began on the 9th of August and lasted for several weeks; my sickness seemed to be due to my having eaten some corn.

In other cases the trouble seemed clearly referable to the use of beans and cucumbers. Sometimes patients got off with only an attack of cramps, in other cases there were, in varying proportions, nausea, headache, vomiting, furred tongue, foul breath, anorexia and diarrhœa; whilst in the severest cases there were symptoms of inflammation of the large and small intestine. There was no doubt in these cases some irritating organic poison developed similar to that which Vaughan found in certain ice-creams. In some of the cases there was frequent micturition and vesical tenesmus, which might have been a reflex symptom or we might suppose that the irritant was eliminated by the kidneys and acted directly upon the vesical nerves in its passage outward in the urine. The following was one of the severest cases of cramp colic that I witnessed.

D. H., a robust colored waiter, age 25, ate cucumbers freely for supper; shortly afterwards he threw up. A little later he was seized with violent cramps and feeling of weight in epigastrium and when I reached him he was rolling and tossing on the ground, groaning and crying out with pain and foaming at the mouth. He had much the appearance of a person in a convulsion and said afterwards that he was unconscious

During the attack. The exacerbation passed off in a few minutes, leaving him with a feeling of soreness and dull pain. Later in the evening he had a return of pain to a less degree, which was relieved by a hypodermatic injection of morphia. The inflammation of the bowels usually began with diarrhœa, which continued for one to three days before the bloody stools appeared, but not always so.

Mr. S. was taken during the night with pain over the loins, followed by straining, griping pains and small, bloody mucous passages. These symptoms continued for thirty-six hours, when he had Epsom salts, followed by Dover's powders. He thus obtained relief, but on too early a return to ordinary diet had a relapse, which was finally cured by the use of pepsin, pancreatin and bismuth. In general, the treatment of these cases was very simple. The use of anodynes, followed by hydrochloric acid, bismuth, pepsin, etc., was all that was required.

One of the worst cases of chronic eczema that I ever saw was that of Mrs. M., of Pittsburg, a childless married woman, age 24. At 8 years of age the eruption began and gradually affected her head, body and limbs, except her hands. She has never been free from it, although it has had periods of improvement as well as exacerbation. Her face was very much disfigured by it, being covered with purplish, red, elevated, dry, scaly blotches, running together in places. On her forehead they formed nearly a continuous mass covered with fine scales. There was itching, but she suffered more from a severe burning sensation. She was a slender, pale woman, and stated that she had lost 20 pounds within a short time; nevertheless she claimed that

her general health was good. She had been under the treatment of various general and special physicians and had taken arsenic and other remedies with benefit but without cure. As she only came to try the water, of the reputation of which especially in eczema she had heard, she only consulted me regarding the use of it and therefore was not under my professional care. She used the water both locally and internally faithfully for six weeks but without the least benefit so far as she or I could see.

One night, about 10 o'clock, the attention of some of the guests was attracted by yells and wild cries proceeding from the rear of the buildings; being summoned in haste I found that the German baker was having an attack of delirium tremens. After drinking heavily for several days, on the night in question he suddenly began yelling and at the same time writhing and kicking and rolling upon the ground. He seized whatever came in his way and dashed it about with superhuman strength. He thus caused a tremendous noise and much alarm among the domestics. He had a malicious manner about him and seemed to roll in the direction of anyone who approached. It was thought that if he seized hold of anyone he would do them serious damage. He seemed disposed to bite himself and others. He had every appearance of a dangerous madman. In the dilemma, one of the strongest of the colored waiters was induced to tackle him and as soon as he had done so others ran to his assistance, one seizing an arm, another a foot, another his head, etc., and thus we succeeded, after many attempts, in gagging him and fastening his feet together and his hands behind him,

Thus placed *hors de combat*, he was dragged into a vacant outhouse. A hypodermatic of morphia seemed to have little effect on him and inhalation of chloroform was equally unsuccessful. I then gave him an enema of hyd. chloral, xl grains, and left him, after midnight, in charge of one of the men, who had been promised a reward by the proprietor if he would stay with him. Next day I learned that he had grown quieter after the injection and had slept most of the night, and I found him in his own room, and rational. He had no further delirium and was discharged on the second day after.

There was a lady at the Springs who had had her ovaries removed, two years previously, at the Johns Hopkins Hospital, and it may interest you to know the result. She had had three children and at the birth of the oldest had suffered a complete rupture of the perineum. Besides suffering from this, her menses used to last a week, being very profuse and accompanied by excessive pain. Dr. K. first repaired the rupture and then removed the ovaries, which were the seat of a dermoid cyst. As a result, she had not had her courses since and had been relieved of her abdominal pain and other local discomforts. Whilst thus so greatly relieved she stated that she was still extremely nervous and suffered from great sensitiveness, the slightest imprudence causing indigestion and loose bowels.

I had an opportunity of rendering some service to a young physician in the neighborhood who was affected with one of those hybrid fevers which have given rise to so much dispute and have for want of a better name and in the absence of a clear pathology been

designated as typho-malarial, under the impression that they are due to a combination of the two diseases named. The atypical character of many such cases was explained by a supposed mutual influence and repulsion producing great modifications in the symptomatology. I will not weary you with a detailed account of Dr. C.'s sickness. He had been ill three weeks when I first saw him, and I visited him three times. He took to bed three days after he began to be ill and his earliest symptoms were frontal headache, nausea, chilly sensations (not repeated) and epigastric pain and tenderness. The temperature was febrile, rising once to 103°, but the febrile exacerbations were confined chiefly to the evenings. The morning temperature, with about two exceptions, declining to normal and sometimes below the normal. His bowels were constipated from the beginning and he took medicines repeatedly to open them.\* My visits were all in the fourth week. He did not at that time present a typhoidal appearance and was able to give an intelligent account of his case, including thermometric observations. I found slight tympanites and tenderness, with complaint of pain at times in the epigastrium, but no tenderness anywhere below the navel. The centre of his tongue was covered with a thick yellow fur, whilst the tip and edges were clean and red. The pharynx appeared red and was partly covered with mucus.

There had been some complaint of obstruction in swallowing in the upper sternal region. His skin was cold and his temperature 98° (in the afternoon).†

\*The nausea recurred but once after the first week. There were never any rose spots and no epistaxis. He had much sweating.

†His pulse at the same time was 102.



No enlargement of the spleen or liver could be made out. There were no abnormal lung sounds to be heard. The heart beat was in its normal site; there was a slight presystolic bruit at the apex. The urine was stated to be passed slowly, as though there were some paresis of bladder. He complained of muscular pains and soreness about the upper and lower extremities and loins. They were most marked in the arms, and the region of the lower biceps in each was swollen, hard and tender and painful on movement. He told me that he had treated himself and had taken twenty-four grs. of quinine every day since his sickness began until the day before I first saw him, for he regarded it as a case of remittent fever. He also informed me that he had had several cases like it in his practice; one of them, a girl, died; the other physician had called it gastric catarrh. The evening temperature as recorded for me for three days was  $101\frac{1}{2}$ ,  $100\frac{1}{2}$  and  $99^{\circ}$ . At first sight one would be apt to pronounce this case one of remittent fever, but why, then, the negative effect of quinine? And the patient had not had evidences of malaria at any time, nor had he been absent from home. It is doubtful if malaria prevails at all in that section, which is at an elevation, it is said, of over 2000 feet above tide-water, and is generally well-drained, open and salubrious. Osler lays great stress upon the impossibility of making a diagnosis in many cases of these fevers by the mere symptoms and relies upon an examination of the blood for a decision. I am not so sure that a distinct form of fever, *sui generis*, will not in time be found to be at the bottom of these cases.

The following bit of experience, which I might entitle "One night's experience as a country doctor," may be novel to you, as it was to me. One afternoon the squire, who was a cobbler, but nevertheless one of the most important personages about the place, and a very honest and worthy person, came to my office accompanied by a countryman. The latter was in his shirt sleeves and his appearance and address indicated that he belonged to the class of simple mountaineers. The object of his visit was to get me to go to see "his gal," viz., his daughter, who he informed me was having a protracted and difficult labor. I told him that I had only come to practice among the guests at the springs and did not wish to interfere in any way with the rights of the physicians in the neighborhood; that I was not prepared to treat such cases as that, having no obstetric instruments, and that he had better secure the assistance of some of the practitioners near by. He replied that the nearest physician (the same whose case I have mentioned above) lived seven miles from him and was too ill to come and that the case was urgent. The squire added his entreaties, saying that he knew the people to be poor and worthy, and he thought honest. I finally consented to go if the countryman would provide a conveyance. He then went away but presently returned in a buggy to which his horse was hitched. We started off about 5 o'clock in the afternoon, he driving. I soon found that he was not accustomed to such a role and that I should have to take the reins if I did not wish to be upset. We had to go a distance of about four miles, most of which was over a

narrow lane badly washed by recent rains. The ruts and gullies in places formed wide chasms two and three feet deep; so we were compelled to alight and walk the entire distance, leading the horse and lifting the buggy over the worst places. We reached the house about sundown. It was a log cabin at the foot of a spur of mountains with the gable end facing the lane. An addition had been made to the farther side, which was used as a kitchen. Through this we entered.

I found the patient in a small inner apartment which had been partitioned off in the main cabin. In the room with her were her husband, his mother, and a female of the neighborhood, who was acting the part of midwife. The patient was a primipara and belonged to the sect of Dunkards who are numerous in that locality. She was a robust woman of about 23 and had been in labor some 36 hours. She occupied a semi-recumbent posture across a bed, with her buttocks at the edge of the bed and her feet resting upon chairs, her knees being supported by the other woman. Her husband sat behind her with his back resting against the wall and his arms entwined about her waist. The posture assumed was exactly that portrayed in one of the plates in Engelman's work on "Labor Among Primitive Peoples." The pains had been powerful and regular for several hours, but there was no progress. During each effort the head descended some inches, but, as soon as it ceased, returned to its former position. I was convinced after an observation of an hour or two that forceps would be needed and explained my views to them, but the midwife knew better and told them that everything was

coming on all right. It was not until 2 A. M. that they felt further delay was unwise and the patient herself began to demand relief. Now the old man had to be awaked and started off on his horse, 14 miles there and back, to get the forceps. I pitied him on that lane, but he knew the road well and fortunately for him the moon was shining brightly. He returned about daylight, bringing a short pair of forceps, which I believe go by the name of Simpson's. I then applied the instrument and soon had a lusty male infant in the world, without injury to mother or child. All were delighted with my skill and a shower of praises was bestowed on me. I was assured that the newcomer was to be named after me and I doubt not I have since been so immortalized. The sun rose bright and clear and I got back to the hotel in time for Sunday breakfast. I was much relieved to get off so happily, for it was not pleasant to be so far away among strangers in such a place and I knew not what might happen if anything should go wrong. Perhaps I may mention as a not unimportant addendum to this story that not long after my return to the city I received through the squire—whose memory I consequently hold very green—the full amount of my fee, a very agreeable and unexpected surprise.

The season was not a blank to me in the way of mental improvement. Instead of giving up my leisure to the amusements of the places I devoted it to a closer study of nervous diseases and electricity, subjects in which I was especially interested at the time, and these subjects will always be associated in my mind with genial sunshine, delicious breezes and the rustling of leaves in the tall trees,

for I sat upon my porch while reading and we had only a few days of disagreeably hot weather there.

I did not expect to tell you anything new in this sketch. My full expectations will be realized if I shall have amused you for a few minutes with a summer's experience in the mountains written *currente calamo*. It may prove at least an acceptable resting place in the midst of the weightier and more scientific articles of the evening.

### OVARIOTOMY ON PATIENTS OVER SEVENTY, BY AMERICAN OP- ERATORS.\*

BY MARY SHERWOOD, M. D.,  
OF BALTIMORE.

In a report of 5 cases of laparotomy performed on patients over seventy years old, published in the *Lancet*, January 21, 1893. J. Rutherford Morison states: "Long lists of successful ovariectomies can no longer serve any good purpose, for it has been proved that the mortality of ovariectomy should not exceed 5 per cent. My excuse for publishing the following cases is the advanced age of the patients. Sir G. M. Humphry long since pointed out that in old people repair and recovery are likely enough to follow major operations. This is true of abdominal sections—a fact not sufficiently recognized." That this last statement is emphasized by facts is shown most conclusively by the statistics in a list of 100 cases of ovariectomy performed on patients over seventy years of age, which I have recently assisted Dr. H. A. Kelly in collecting. While a complete

tabulated statement of these cases, with an analysis of the same and inferences drawn therefrom, is reserved for publication in the *Johns Hopkins Hospital Reports*, at the suggestion of Dr. Kelly I have taken the cases reported by American operators as the basis of the present paper.

That special attention might be called to the cases of American surgeons seems appropriate as this list includes: 1. The earliest case found in the literature on the subject; 2. The oldest case on which ovariectomy has been successfully performed; 3. The greatest number of cases reported by any single operator.

The first ovariectomy on record as having been performed on a woman over seventy years old, was the case of E. P. and W. C. Bennett, of Danbury, Conn., who, on the 17th of August, 1861, operated on a patient aged seventy-five years. An incision two inches long was made and seven or eight sacs emptied with a trocar. Silk sutures were used in closing the abdomen. The patient "recovered without any mishap."

To Dr. John Homans, of Boston, belongs the honor of having operated on the oldest case on record. In the *Boston Medical and Surgical Journal*, May, 1888, he reports a case of ovariectomy in a patient aged eighty-two years and four months. He removed a multilocular cyst of the left ovary, weighing fifteen pounds, and in December, 1892—four years after operation—reports the patient alive and well. In addition to having operated on the oldest case recorded, Dr. Homans reports 12 cases of ovariectomy in women over seventy years of age, the greatest number accredited to any single operator.

\*Read by invitation of the Board of Directors before the Philadelphia County Medical Society.



The table included in this paper contains 38 cases from the original list. Of this number, 33 recovered from the operation, 5 died, giving a mortality of 13.1 per cent. The mortality as based on the complete list of 100 cases is less than this (12 per cent.). The results of the operation are, therefore, very encouraging when one considers that, according to Bland Sutton, in experienced hands the mortality of ordinary ovariectomy varies from 5 to 10 per cent. This rate of mortality becomes increasingly suggestive when it is noted that in the series only 9 cases are reported as simple and uncomplicated. In 23 cases adhesions were more or less numerous, necessitating in 2 cases the removal of the uterus. In this connection the table seems to establish the fact that age in itself need not be considered as an additional factor in the prognosis of ovariectomy. In the case of Boldt, the patient was seventy-four years old, cachectic, and much emaciated, with moderate ascites. The entire tumor was firmly adherent, many adhesions so dense as to require severing with scissors or knife; there were also adhesions with intestines. The retro-peritoneal glands were enucleated. The tumor proved to be a multilocular cyst of the left ovary of which the lower and posterior portions as well as the enucleated glands were carcinomatous. This operation was performed in March, 1887, and Dr. Boldt reports the patient as still living—nearly six years after operation. In one of Homans' cases the tumor was so adherent to the uterus that the body of the uterus had to be removed also. The case was that of a woman, aged seventy-two, from whom Dr. Homans had removed the right ovary five years previously, who

had remarried after recovery from this operation, and from whom he now (1877) removed a multilocular cyst of the left ovary together with the uterus. In December, 1892, he reports the patient as living and well. In June, 1890, Dr. H. Marion Sims operated on a patient aged seventy years, removing a multilocular cyst of right ovary, weighing eight pounds, adhesions being so extensive that he was obliged to remove the uterus also, and the patient recovered and is reported as still living in January, 1890.

As the nature of the tumor is an important factor in estimating the results of the operation, an examination of the table shows that the most frequently occurring tumor is the multilocular cyst. Unfortunately, in a majority of the cases there is no histological report of the nature of the tumor extirpated. In one instance—a case of Dr. Kelly's—a careful microscopical examination showed areas of adeno-carcinoma in the cyst wall; another cyst was cancerous at base with involvement of the retro-peritoneal glands, while two of the multilocular cysts are reported as papillomatous; sarcoma, dermoid, solid tumor are noted once respectively, and in seven instances the cyst is unilocular. The absence of results of microscopical examination in some cases makes it impossible to reach any accurate decision as to the percentage of malignancy, although in seven instances the tumor is stated to be non-malignant.

With regard to the ovary affected, we have the statement in 27 cases, in 10 of which the tumor was of the right ovary, while in 17 the left was affected. It is interesting to note that in our list of 100 cases, 72 of which report on this

point, the right ovary is involved in 38. the left in 32 cases (in 2 cases both ovaries being affected). No evidence is, therefore, afforded that either ovary is the more frequent seat of disease.

The time of first appearance of symptoms in the majority of our cases shows that the tumors were for the most part rapidly growing, in 6 instances the observation being made less than one year before operation, while in 19 the time was between one and two years. The remaining 6 cases which report on this point give a time varying from three to ten years.

The subsequent history of these cases is a point of great interest, and here, too, the facts of our table give definite information in many instances. As was stated above, 5 patients died within ten days after operation. Of 8 cases reported as dying subsequently, 4 lived less than a year, while 4 others lived from five to ten years after operation. The cause of death in these 8 cases is variously given—pneumonia, heart disease, old age, etc.

Eighteen patients recovered from the operation and are reported as living at present, *i. e.*, in January, 1893, when the facts for the table were collected. In 2 cases only was this report given less than a year after operation. Nine patients were alive and well one to three years after, and 7 have survived operation and are still living from three to ten years after. Evidently we can draw no conclusion from the after-history of the patients against the advisability of operating on the aged, in the face of the fact that 16 of these 38 patients lived from two to ten years after the operation was performed, 12 of this number being alive at present.

The facts shown by our statistics summarized briefly are:

First. That the operation of ovariectomy in the aged presents no essential differences from this operation in cases of younger years.

Second. That the percentage of recovery from this in patients over seventy, as shown by the results of American surgeons, in 86.8 per cent., the mortality 13.1 per cent.

Third. That the indications and contra-indications for ovariectomy in the aged are essentially the same as for this operation in general.

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Dr. Stowell, the editor of *Food*, in a recent issue takes exception to the doctrine that over-activity is destroying the life of our nation. He says:

Some writers would make us believe that the length of a man's days is in inverse proportion to his hurry. It is our opinion that by far a greater number of persons suffer from inactivity rather than from overwork. Hard work is conducive to long life. We should be cautious about advising too freely that less work be done and more hours be spent in rest. For general advice, leaving out, of course, individual cases, we would state that for physiological, philosophical and statistical reasons, the active, persistent work as exemplified by American life conduces to a happy old age.

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We are requested to call attention to the approaching meeting of the Southern Surgical and Gynecological Association, which will be held in New Orleans on the 14th, 15th, and 16th days of November. Members of the medical profession are cordially invited to attend. Dr. Bedford Brown, President, Alexandria, Va. Dr. W. E. B. Davis, Secretary. Birmingham, Alabama.



## MARYLAND MEDICAL JOURNAL,

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A. K. BOND, M. D., Editor.

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BALTIMORE, SEPTEMBER 30, 1893.

**Editorial.****IN PARTING.**

With the present issue the editor lays down the burden of responsibility for the literary conduct of this JOURNAL, which he has borne during the past two years.

The inherited longing for editorial life which beset him in the earlier years of his medical career has been fully satisfied; and he turns now with singleness of purpose to the multiplying duties of his true calling, the practice of medicine.

Of the shortcomings of his administration no one perhaps is more painfully aware than himself; yet in view of the difficult nature of his task and of the distracting obligations of his professional engagements, he can testify with clear conscience that he has done what he could, under the circumstances, to supply to his readers week by week a journal of practical value in daily medical life.

Amid the cares of editorial labor and

above the grumbling of chronic fault-finders, have sounded with peculiar gratefulness the appreciative words of subscribers who possess the happy faculty of enjoying the solid good which comes into their life, without being soured by a continual grasping after their own nebulous ideals.

To those subscribers who have cheered him with words of approval, of encouragement, or even of wise criticism, the editor would return most sincere thanks. To those friends who from far and near have contributed to the "original article," the "correspondence," and occasionally to the "editorial" columns, he would but speak the gratitude and appreciation which on many occasions has filled his heart.

To leave the JOURNAL improved in its general appearance and more full than ever of able practical thought; and to have taken some part in the upholding of noble medical standards in our State; in the quickening of thought among medical men; and in the promotion of *esprit de corps* in the profession, is sufficient.

To our successors we resign the more distinguished work of developing a publication which shall embrace in its columns all the best work of the as yet ununited medical practitioners and teaching faculties of Maryland.

**FURUNCLE IN THE EAR.**

Every physician knows what a painful affection this is; and knows likewise how unsatisfactory most of the vaunted remedies are. Few disorders of the same extent of surface produce in persons of nervous temperament such diabolical



torture; and few pursue their course to self-healing with such perfect disregard of measures, simple or painful, designed to abort them.

In the *Annals of Ophthalmology and Otology*, July. Dr. Barrett gives his experience on the subject. In regard to causation of the disorder, we gather from his disquisition that, like other writers, he doesn't know what it is. The diagnosis is sometimes simplified by the patient's laconic statement that he has a boil in his ear. In regard to treatment, Dr. Barrett says:

This disease yields very readily to proper and judicious treatment, and a favorable prognosis can always be given. If the trouble has existed for some little time and the patient is becoming exhausted from the continued suffering, or if the swelling is great and a point is seen which has opened a little, or is about to open, then an incision with the knife is the quickest and most efficient means of relief. But I believe that this will rarely be called for. If it is seen early in its course, I believe that a furuncle in the ear can be aborted in the large majority of cases.

The local abstraction of blood by means of one or two leeches applied to the tragus may be of service, but even this is rarely necessary. A brisk purge will effect sufficient depletion, and should be one of the first steps in the treatment. One or two grains of calomel, given in one-eighth or one-fourth grain doses one hour apart, is the favorite mode with the writer.

Dry heat, in the form of hot flannels, a hot salt-bag or a hop-pillow, applied to the ear, is ordered for the relief of the pain. And in exceptional cases, mor-

phine in eighth-grain doses is prescribed for the first day or two. The surface of the swelling is covered well with an ointment consisting of twenty grains each of extract of arnica and extract of belladonna to an ounce of lanoline, or whatever base is preferred. A pledget of cotton is inserted into the canal as tightly as can be borne, and the patient told not to remove it unless the pain caused by its pressure is too severe. This is repeated each day, or twice a day if possible, and under such treatment a furuncle will disappear very readily.

If the swelling is so great as to render the application of the ointment difficult, a very nice application is equal parts of the "black-wash," the officinal lotio nigra, and glycerine. A small pledget of cotton is thoroughly soaked in this and placed well into the canal and left there for ten or fifteen minutes and then it is replaced by a dry piece, put in as tightly as possible.

Burnett recommends the "black-wash" alone, and also an ointment of Hydrargyri ammoniati, grains one to two to the ounce of some base, such as cold cream. Dr. H. N. Spencer, of this city, speaks very highly of the use of a 4 per cent. solution of ichthyol in water, applied the same way as the black-wash and glycerine. If it is thought best, the pledget of cotton wet with the solution may be allowed to remain in the meatus, instead of its being replaced by a dry one. In one case under the writer's observation the solution of ichthyol certainly seemed to act well. Cholewa (*Berlin Monatschr. f. Ohrenheilk*, etc., 1892, No. 3) had advised the use of a ten per cent. solution of menthol oil introduced on cotton pledgets, claiming that the

pain is relieved the first day, and that new boils do not appear. The menthol is said to stop the development of the staphylo-coccus pyogenus aureus and the strepto-coccus pyogenes. (A carbolic salve will prevent new boils.

The constitutional treatment of these cases is very important. The cause of the trouble should be sought out and eradicated from the system if possible. Most patients will need a tonic treatment, and some of the preparations of iron and quinine should be prescribed, as the individual case may suggest.

Sexton and others speak well of the use of sulphide of calcium in small doses. Each case must stand on its own merits and be treated, both locally and constitutionally, as the conditions may demand.

And with careful attention a furuncle in the ear may soon be disposed of, and the development of new ones be prevented.

Our impression after reading the above-quoted directions are that the author never personally suffered from such boils in the ear as we have sometimes had to treat. The pain in these was excruciating; the whole head throbbed with exquisite torture; incisions caused wild cries of pain, and left long-continued aching, and, moreover, did not do the least good. Packing compresses into the canal was out of the question, and instead of being contented with promises that in a day or two the trouble would subside, the patient demanded immediate relief.

Heavy doses of cathartics and morphia by the mouth, with local application of heat, were efficient, but seemed much too slow in action.

Patients have reported rapid cures by "homœopathic remedies," perhaps aconite. The pain seems to be due more to nervous over-sensitiveness than to the local inflammation.

#### A WORD OF APPROVAL.

In rebuke to pessimists and in encouragement to admirers of our JOURNAL, we note the favorable comments which recent issues of our JOURNAL have elicited from our able compeer, Dr. Stowell, who has given to Washington City an unique journal of medical criticism, the "*National Medical Review*," and, later, an admirable hygienic journal, "*Food*."

The former publication commented very approvingly some weeks ago upon our championship of the therapeutic value of "Merry Laughter;" from the latter we excerpt the following paragraph, protesting, however, with all the modesty of a modern belle, that we are not *thirty*, but only *seventeen* years of age.

Dr. Stowell says in the September number of "*Food*:" The MARYLAND MEDICAL JOURNAL is a close neighbor of ours, and has been a visitor to many doctors' offices for nearly thirty years. It reaches us regularly once a week, and is always read with the expectation of stealing something from its pages. This time it is in reference to a recent editorial on the Therapeutics of Mental Diversion. Dr. Bond thinks that variety is not merely the "spice of life," "it is rather an essential ingredient in the pabulum of normal existence for all sentient organisms." Believing in this accounts for our thrusting on the profession such an article of "food" as is found in this journal. Two articles of a

general character have recently appeared of much interest. We refer to the one by Dr. Barnes on the Evolution of Medicine, and the other by Dr. S. C. Chew, given as an address before an alumni association.

### Reviews, Books and Pamphlets.

We have received from P. Blakiston Son & Co., advance-sheets of a New Illustrated Dictionary of Medicine, Biology and Collateral Sciences, by Dr. George M. Gould, already well known as the editor of two small medical dictionaries, now about ready, an unabridged, exhaustive work of the same class, upon which he and a corps of able assistants have been uninterruptedly engaged for several years.

The feature that will attract immediate attention is the large number of fine illustrations that have been included, many of which—as, for instance, the series of over fifty of the bacteria—have been drawn and engraved especially for the work. Every scientific-minded physician will also be glad to have defined several thousand commonly used terms in biology, chemistry, etc.

The chief point, however, upon which the editor relies for the success of his book is the unique epitomization of old and new knowledge. It contains a far larger number of words than any other one volume medical lexicon. It is a new book, not a revision of the older volume. The pronunciation, etymology, definition, illustration, and logical groupings of each word are given. There has never been such a gathering of new words from the living literature of the day. It is

especially rich in tabular matter, a method of presentation that focuses, as it were, a whole subject so as to be understood at a glance.

The latest method of spelling certain terms, as adopted by various scientific bodies and authorities, have all been included, as well as those words classed as obsolete by some editors, but still used largely in the literature of to-day, and the omission of which in any work aiming to be complete would make it unreliable as an exhaustive work of reference.

The publishers announce that, notwithstanding the large outlay necessary to its production on such an elaborate plan, the price will be no higher than that of the usual medical text-book.

From the sample pages sent us we judge that the dictionary will be just what is necessary for the practising physician. The pronunciation of words is well marked, and the type is good. If the promises above made are fulfilled, as doubtless they will be, the editor will have given us the best dictionary yet known to us.

*Dunghlson's Medical Dictionary*; Embodying forty-four thousand new medical words and phrases. One magnificent imperial octavo volume, 1200 pages. Cloth, \$7.00; leather, \$8.00. Lea Brothers & Co., Publishers, Philadelphia. 706, 708 & 710 Sansom Street.

A dictionary of medical science. Has a full explanation of the various subjects and terms of anatomy, physiology, medical chemistry, pharmacy, pharmacology, therapeutics, medicine, hygiene, dietetics, pathology, surgery, ophthalmology, otology, laryngology, dermatology, gynaecology, obstetrics, pediatrics, bacteri-



ology, medical jurisprudence and dentistry, etc. By ROBLEY DUNGLISON, M. D., L. L. D. New (twenty-first) edition, thoroughly revised and greatly enlarged. With the pronunciation, accentuation and derivation of the terms. By Richard J. Dunglison, A. M., M. D.

### Medical Progress.

#### LEUCOPLASIA OF MOUTH.

At a recent session of the California Medical Society (*Pacific Medical Journal*, May) an interesting article was read upon this subject by Dr. D. W. Montgomery. In the course of his paper the doctor remarked that "by the term leucoplasia is meant the appearance of bluish white, more or less nacreous patches occurring either on the mucous membrane of the dorsum of the tongue, or the internal surface of the cheeks, on the lips, on the vulva, or possibly also on the internal surface of the prepuce; and its great interest lies in the fact that it is a precancerous condition. Four cases of this affection were reported, one having leucoplasia of the tongue, due to syphilis and smoking; other two of the lower lips, due to smoking and eczema; and lastly one of syphilitic glossitis, who does not smoke and has not eczema. In the treatment of such cases it is of the first necessity they should stop smoking; then the hygiene of the mouth must be attended to. If they have a syphilitic lesion one must be careful not to salivate and also to stop antisyphilitic treatment should it aggravate the leucoplasia. Quite a number of authorities are of the opinion that if the patches are small and well

circumscribed they ought to be burnt out thoroughly with a thermo-cautery, taking care to go well into sound tissue both below and at the sides of the patch. They take the ground that the affection is a threat, a dangerous factor, which ought to be got rid of and replaced by cicatricial tissue. There can be no doubt, however, that an operation ought to be performed as soon as symptoms of cancer appear, and the patient should be made aware of these symptoms and of their grave nature. Leloir and Vidal have formulated them as follows: (1) When a patch which has hitherto been smooth becomes warty. (2) When a patch which has hitherto been supple and thin begins to thicken and a nodular induration forms below it; and (3) When a fissure or ulcer proves rebellious to treatment and a belt of induration forms around it."

#### UTERINE ADHESIONS WHICH ARE PUZZLING.

In an article upon "The Diagnosis of Uterine Adhesions," Dr. Dudley (*N. Y. Gynec. and Obstet.*, May) says:

The string-band adhesions are the most difficult to diagnose that we have to deal with, for they give the least trouble so far as the constitutional effect upon the patient is concerned and are the easiest amenable to treatment. There are cases where a patient has had a slight peritonitis, where there has been an exudation, and a veil of lymph thrown across from some portion of the uterus to the sacrum posteriorly; and where time, with the efforts of nature and the treatment by the physician has relieved those adhesions to such an extent that the once firm veil thrown across the pelvis has been absorbed to such an extent that it is drawn into fibrous strings

of adhesions; these serve as a means of imprisonment for the uterus within a certain space. Those are the conditions that will puzzle you the most. I am now speaking of pelvic adhesions that are inflammatory and existing between the uterus or the appendages and the pelvic wall. There are many conditions of adhesion within the pelvis which would be included under that term that are not related especially to the uterus. I am referring to the adhesions between the omentum and the abdominal wall, the omentum and the bladder, the omentum and the intestines, or, if you please, the omentum and a portion of some other organ within the abdominal cavity, and all of which will puzzle you, and will, perhaps, call for surgical treatment as much as those I have spoken of, but still will be very difficult of diagnosis. Such conditions you have undoubtedly seen as intestinal adhesions between loops of intestines, adhesions between the omentum and the abdominal wall, or between some other organ within the pelvis, as a prolapsed kidney or a prolapsed spleen—these I do not consider come within the province of this discussion and for that reason I dismiss them.

#### PROPHYLACTIC PURITY.

The following extract from Dr. Parvin's presidential address before the American Gynecological Society (*American Journal of Obstetrics*, June) should be read with respectful attention: As physicians and philanthropists, our duty to care especially for the health of women and to protect them from disease, and knowing countless cases of wives made sterile, their health more or less seriously impaired, by the licentiousness

of husbands who regard the seventh commandment as obsolete, we cannot ignore what has been called the social evil. If we content ourselves, as so many do, with declaring it a necessary evil, and utter no warning, make no effort to arrest the black tide of disease and death, of sorrow and suffering and crime, we do not meet the grave responsibility of the hour. We who are priests at the altar of woman's health are derelict in duty if we do not throw around it all possible protection.

What if the immortal Jenner had said Small-pox is a necessary evil, and therefore I will do nothing to avert or to mitigate the scourge? So, in the presence of great moral and physical evil, let us beware of saying nothing can be done to avert or mitigate. My own belief is that if fathers were as careful to inculcate lessons of chastity upon their sons as mothers upon their daughters; if that double standard of sexual morality which prevails in society, regarding the licentiousness of the young man as venial, while it brands his sister who lapses from virtue as an outcast, never to be forgiven, were forever abolished; if the true horrors, loathsomeness, and perils of prostitution were made known in a proper manner to young men—if the moral forces of good men and of good women could be combined, guided by the intelligent and zealous devotion of physicians, bearing full high advanced the White Cross, I am sure that a brighter, better day would dawn and a reign of social purity prevail.

#### PARASITES IN CANCERS.

The *N. O. Med. & Surg. Jour.*, June, gives a translation of a paper by Dr.



Korotneff, of Kiev, on the Rhopaloccephalus Curcimomatosus, in which, after describing the alleged parasite, he says:

A very debatable question is the relation of parasites to the etiology of cancer; we can form a very reasonable conjecture. We find a clue in the question: What influence does the parasite described exert upon the cancer-cells in which it finds itself? It has already been stated that the parasite causes the invaded cell to swell up without becoming enlarged itself. This peculiarity is noted in the surrounding cells: the cells do not enlarge, the carcinoma does not grow under the influence of the parasite, and I might say further, that the cancer-cells grow precisely at the points where no parasite is present. The ground is not produced by the parasite, but, nevertheless, the change that it brings on is very significant. The observations already made show that the regressive process, which characterizes cancer, arises from the rhopaloccephalus, which produces necrosis of the cells and the destructive influence which the new formation exerts upon the general system. I venture to say that, theoretically, a carcinoma without parasites can have no special bad effect practically, or better, clinically, carcinomata appear to act upon the organism in different ways; the disease, as is well known, often assumes a very latent form; and I have been informed by several clinical authorities that in old age forms of cancer appear that run their course without affecting the lymphatic glands. I might say that these non-infections are, in a measure, harmless, and probably non-parasitic; thus a carcinoma is a harmless epithelial new-formation which may be compared with any other epidermic formation (hair,

hoofs, claws, corns). Quite another question is this: Wherein lies the impulse of an abnormal epidermic formation of a cancer? Here, however, we may say that numerous clinical observations authorize us to say that the answer is to be found in a traumatic cause, which gives rise to a local disturbance of nutrition.

#### SUCCESSFUL REPOSITION OF THE CORD.

The repetition of medical experiences becomes in certain cases tiresome, but cases such as that given by Dr. Tildesley in the *Lancet*, September 9, are so instructive that they always bear quotation. He says: I venture to record the following case as being one of interest (1) from the rarity of its occurrence—1 in 245 deliveries (Churchill) and one in 254 (Scanzoni)—and (2) from the still greater rarity of a successful result as regards the life of the child. I was called a few days ago to see a married woman aged thirty-five, multipara, who had four children living, the previous labors having been instrumental. On abdominal palpation I found the axis of the child to be longitudinal, the breech being felt at the fundus and the back directed to the right. On vaginal examination the os was found to be fully dilated, the membranes were unruptured and a knuckle of funis was felt in front of the presenting part. The patient was placed in Sim's semi-prone position on the opposite side to that on which the cord had descended. She was kept in this position and on examining her again after two or three pains the funis had receded. She was now fully anæsthetized, and the membranes were ruptured, the result, unfortunately;



being a sudden gush of liquor amnii, leading to a prolapse of the cord. Pulsation was only very feebly distinguishable. Still maintaining the semi-prone posture, with the hips elevated, the hand was introduced into the vagina and the loop of the cord was pushed up by the fingers above the head, the external hand then making pressure on the fundus. Simpson's forceps were applied and the head was rapidly delivered, the child being extracted in a condition of grave asphyxia. Restoration was attempted by alternately dipping in hot and cold water, but without success. The air passages being cleared of contained fluid by suction, Schultze's method was employed and was rapidly effectual in restoring animation.

*Remarks.*—The following points are worth noting: (1) The absence of any pelvic deformity or any malposition of foetus, an unusually long cord being the only recognizable cause of the prolapse; (2) the great ease with which reposition was effected without resorting to the genu-pectoral position; and (3) the advisability of rapid delivery and repeated attempts at restoration, even though pulsation may have apparently ceased in the funis.

#### EUSTACHIAN SYNECHIAE.

In a recent address before the *British Medical Association* (as reported in its *Journal* of September 9th, 1893) Dr. William Robertson, after referring to his paper on this subject, published in the *British Medical Journal* some years ago, said that when the pharynx tonsil became abnormally enlarged in a nasopharynx of perhaps restricted development associated with ostia tubæ, protruding more than usual into this space,

as was often noticeable in this crowded condition of parts, adhesions were apt to take place between tufts of the pharynx tonsil overlying the upper limits of the ostia tubæ. According to the subsequent changes in the tonsil, these adhesions remained of a fleshy consistence, or, as the tonsil receded and atrophied, they were found to resemble white fibrous bands of a length corresponding to the limits of the space and the degree of retraction of the tonsil. This recession of the tonsil and retraction of adherent bands gave rise to various forms of deformity of the mouth of the tube. A rosy red injection and a thickening of the substance of the ostium was observed in the neighborhood of the insertion of the synechiæ. The normal round character of the opening of the tube was in these cases always altered. When the synechia was attached to the upper limits of the tube, then the opening was triangular. When attached to the posterior aspect, then the opening became slit-shaped. It was difficult in any case to say how far these synechiæ were potent in the etiology of deafness. It would be admitted that where they existed the middle ear had for long from other causes been exposed to the evil influences of catarrh in the naso-pharynx, as these bands presumably only arose in cases in which extreme hypertrophy of the pharynx tonsil had been in existence. That these bands perpetuated catarrhal conditions in the tube at their insertion into it could be actually observed and demonstrated. These catarrhal conditions might be propagated into the middle ear. It would also, probably, be admitted that the distorted opening of the ostium militated against the free egress

of mucus from the tube, and hampered free ventilation of the tympanum, so necessary to the function of hearing. The thick fleshy adhesions formed by the meeting of thick bands of lateral granular pharyngitis with the lower aspect of the ostium must also be noted. In considering the question of how far in any case these synechiæ affected a case, and the share they bore in the etiology of the accompanying deafness, the condition of the middle and external ear must be investigated. In some cases synechiæ were discovered where little injury to the middle ear or to hearing was apparent. Generally the case was otherwise. Now and then cases were met with in which it was the only lesion discoverable, but was associated with tubal catarrh with depressed drum, etc. Rupture of the synechiæ and after-applications of the air douche restored hearing to a satisfactory extent in such cases. In another class of cases these synechiæ were associated with a condition of middle-ear catarrh of a more insidious and less curable character due to the long exposure of the ear to the repeated assaults of catarrh and swelling in the pharynx. Even before these synechiæ had been formed the ear had probably suffered severe change. These facts showed the imperative necessity of an early and complete removal of the pharyngeal tonsil. If sclerosis of the tympanum, or if a previous suppuration within the tympanum were associated with these synechiæ, the mere treatment of the latter would not effect a great improvement, but as the diagnosis of any case was narrowed down to the existence of mere tubal catarrh, it could be safely stated that the treatment of these synechiæ would immensely favor

the desired result. For the purpose of destroying these bands the galvano-cautery was impracticable and useless. A much more extensive destruction was necessary. The finger was the best means to effect this, carried up to the bands, which were readily felt. The resistance to rupture was often considerable. The finger was carried round the tube, so as to rupture not only those attached superiorly, but also those extending from bands of later granular pharyngitis inferiorly. There was often considerable bleeding, which of itself often acted beneficially on the ear. Subsequently the periphery of the tube was daily swabbed with a four per cent. solution of nitrate of silver to remove the collateral hyperæmia of the mucous membrane which was present. The air douche with catheter or Politzer's bag was, of course, to be used. When only tubal catarrh had been the cause then recovery was rapid and satisfactory, but even in more advanced and chronic conditions with the tympanum the same treatment must be carried out.

#### VALUE OF INTUBATION IN CHILDREN.

In a recent lecture, Dr. Pitts, of St. Thomas's Hospital, summed up thus the results of intubation:

After a careful consideration of the *post mortem* records of uncomplicated cases of diphtheria—treated by intubation at St. Thomas's Hospital, Great Ormond Street, and the Victoria Hospital for Children—I am satisfied that extensive ulceration is quite exceptional. I have heard of a case in a provincial town where, although recovery took place (after subsequent tracheotomy), permanent occlusion of the larynx resulted. This

condition of complete occlusion has, however, followed recovery without any intubation.

At Great Ormond Street Hospital for Children the first trial of intubation in diphtheria was very unfortunate. Eleven cases were intubated in 1890, with 1 recovery. It is only fair to add that owing to the bad results obtained at first, intubation was reserved for those cases which seemed least likely to recover. During 1891 and 1892 no diphtheria cases were intubated, but lately the method has been tried again with considerable success.

In the second series we have 11 intubations with 3 deaths, or over 72 per cent. recovery. In 2 of the cases, however, there was no certain evidence of diphtheria, but in 1 intubation was only done just before death, to relieve the distress of dyspnoea; and in the other 2 fatal cases tracheotomy had also been performed. If to these we add the 11 intubated in 1890, we have a total of 22 cases with 9 recoveries, or notwithstanding the unfortunate commencement, over 40 per cent. recovery return. This shows that the trial has been fully justified, and I do not wish to prove more. My own feelings are in favor of tracheotomy as a routine operation for the relief of obstructed breathing in diphtheria but I believe that equally good results can be obtained by intubation, and that the nature of the case, the surrounding conditions, the age of the patient, and the previous experience of the surgeon, and the consent of friends, must be the chief factors in determining the choice of method.—*Brit. Med. Jour.*

#### TREATMENT OF INSOMNIA.

In an article recently presented to the

Kentucky State Medical Society, Dr. Pope (*American Med-Surg. Bull.*, July) says:

All insomniacs need tonics; hence the cases can be divided into (a) anæmic, and (b) plethoric ones.—(a) In anæmic cases, iron in full doses, with quinine and nuxvomica or zinc or phosphorus, will be found of some value. Iron, when used in conjunction with the douche and rain bath, is doubly efficacious.—(b) For the plethoric cases, I have found strychnine of value—restoring, as it does, the vaso-motor tone; quinine as a tonic-stimulant; and hydrobromic acid, relieving the cerebral congestion and acting as a sedative;—a combination of great usefulness.

If the urine contains phosphates and oxalates, give nitro-hydrochloric acid.

To favor sleep, I have found the bromides, in combination with full doses of ergot and digitalis, of unquestioned value. I prefer the lithium and sodium bromides, as they are the best hypnotics of the bromide salts, containing 92 and 78 per cent. respectively of bromine. Many drugs have been suggested, but these are the most useful.

I consider hypnotics *dangerous*.

The grave responsibility of suggesting a sufficient quantity of alcoholic or malt liquors to produce sleep, and the dangers of forming a habit from such a prescription, is not to be forgotten when the patient is told to take a toddy at bedtime.

Morphine is never used for the relief of insomnia. Chloral hydrate I rarely use. The dull, heavy feeling, the headache, gastric disturbance, and anæmia, induced by such drugs, are just additional burdens of relief. Hyoscyamus dries the mouth, dilates the pupil and



causes intense malaise. Paraldehyde has a nauseous taste and causes transient albuminuria. I have not used it for two years. With sulphonal, the dose must be increased; and the drowsiness felt on the next day may amount to pain. I have seen one case of undoubted sulphonal-habit. Chloralamide has in nearly every case caused unpleasant dreams, a bad taste in the mouth and a heavy feeling the next day. I have not given hypnal a sufficient test to express an opinion.

I do not wish to run down the hypnotics; but I *do wish* to enter an earnest protest against their present *universal* administration. They are two edged swords; and it has always been a question with me whether the good they do is not offset by the harm they cause. No less distinguished physicians than Dr. Ferguson and Dr. Baker enter the same strong protest against their use. Why should a hypnotic be given, when other measures less inimical to the welfare of our patient may be used, and made to yield better and more permanent results? I believe that under an intelligently-arranged hygiene, assisted by the methods before-mentioned, with the help of tonics not hypnotics, sleep can be regained, and regained in a way that will leave the body in a state of excellent health.

In conclusion, it were well for all of us to remember that "No man can gain time by stealing it from sleep."

#### GONORRHOEAL MYOCARDITIS.

A paper read on this subject before the Association of American Physicians by Dr. Councilman is epitomized thus in the *Boston Med. & Surg. Jour.*:

There have always been two opinions

held about the secondary infections following gonorrhœa; one that they are due to the accidental infection with other organisms which enter through the lesions in the urethra, produced by the disease. Gonococci have been found by various observers in these secondary lesions. Other observers have failed to find them. The most prominent secondary lesions consist of the various joint affections, of peri- and endo-carditis, and of inflammation of the neighboring lymph glands giving rise to the bubo. Chronic inflammation of the Fallopian tubes in the female is now very generally regarded as due to a previous infection with gonorrhœa. In a case recently seen at the City Hospital there was an acute urethritis, acute inflammation of the joints and an extensive peri- and myo-carditis. Gonococci were found in all of these places. The lesions in the urethra closely simulate those described by Bumm in his experimental work on the disease. The gonococci were found only in the superficial layers of the epithelium. In the sub-epithelial tissue there was marked round-cell infiltration. It appears probable from a general consideration of the secondary infections that they are true infections resulting from the presence of the gonococci. In the cases in which organisms have not been found it is very possible that they were so few that the ordinary microscopic investigation would not reveal their presence. That the affection is not due to the presence of pus organisms is shown from the fact that the cultures made from these secondary lesions are so generally sterile.

Dr. F. S. Parsons has been appointed editor of the *Philadelphia Times and Register*, to succeed Dr. A. F. Waugh.

### Recommendations of Therapeutic Agents.

#### ALUMNOL IN RHINOLARYNGOLOGY.

For the investigation of the value of the new soluble preparation of aluminium, designated by the above name, in affections of the upper respiratory tract, we are indebted to Dr. Albert Spengler, Assistant Physician to the Heidelberg Outpatient Clinic, for pharyngeal, laryngeal and nasal diseases. The cases treated (20 in number) were chiefly various forms of acute and chronic inflammation of the mucous membrane, and the remedy used was in  $\frac{1}{2}$ , 1, 2, 5 and 10 per cent. aqueous solution. The duration of the treatment in acute cases varied from a few days to two weeks, and in chronic cases, from one to two months. In two acute cases of pharyngitis, cure was effected in from four to eight days, and in two of the chronic form, in two or four weeks, by painting with 5 per cent. Alumnol solution; in 4 other cases of chronic pharyngitis, decided objective and subjective improvement was obtained. Such troublesome symptoms as feeling of dryness, stinging pain sometimes shooting to the ear, slight loss of voice, disappeared, while at the same time the mucous membrane assumed a more normal appearance, and the volume of the secretion was reduced.

After daily clearing out the pharynx with 5 per cent. Alumnol solution for only two or three weeks, the mucous membrane lost its dull dryness in pharyngitis sicca became moister, and the secretion changed from thick tenacious blackish brown masses, to a thin yellowish liquid of small volume. The 5 per

cent. solution was eventually exclusively used, as weaker solutions proved inactive, and stronger were very irritating.

In three cases of slight laryngitis acuta, cure was effected in four to eight days after treatment with 20 per cent. Alumnol solution, but in 4 cases of laryngitis acuta gravis, daily paintings with 6 per cent. Alumnol solution, for a few weeks only, brought about a subjective and objective improvement. In one instance, a very severe acute laryngitis with complete aphonia and manifest epithelial opacity on both vocal cords, improved with extraordinary rapidity on a daily application of 5 per cent. Alumnol solution, so that within a week approximate cure was attained.

The author, in summing up, points out that Alumnol can do good service in various forms of laryngitis, especially pharyngitis sicca. Though not superior to a 1 or 2 per cent. chloride of zinc solution in therapeutical effectiveness, it appears to be less unpleasant to the patient.

### Medical Items.

The Southern Surgical and Gynæcological Association will hold its next meeting in New Orleans on the 14th, 15th and 16th of November.

Dr. G. B. Lawrason has been appointed coroner of New Orleans Parish by Governor Foster, to fill the vacancy caused by the death of Dr. Seeman.

The Fifth Annual Meeting of the Tri-State Medical Society of Georgia, Alabama and Tennessee will be held in the Unitarian Church, 514 Houston Street, between Oak Street and McCallie Ave-



nue, Chattanooga, Tennessee, Tuesday, Wednesday and Thursday, October 17, 18 and 19.

The West Virginia Medical Society has elected the following officers for 1893: President, Dr. R. W. Hazlett, of Wheeling; Secretary, Dr. D. Mayer, of Charleston. Berkeley Springs will be the next place of meeting.

A Kentucky woman who concluded her medical studies this spring brought home in one arm her diploma and in the other her week-old babe. Another woman, in Kansas, not long ago celebrated her election as town mayor by giving birth to a child on the same day. Which either proves the superiority of woman over man by way of versatility and endurance, or it may be accepted as a protest by nature against modern attempts to set insuperable barriers.—*Ex.*

According to the *Lancet*, the multiplication of deeds of violence among the Latin peoples of Europe can be distinctly traced to use of stronger drinks. In Southern and Central Europe the human subject is even more susceptible than the dwellers to the north, to the evil influences of alcoholic intoxicants. Even the nationalities dwelling along the Mediterranean have, from this cause, during the last decade, raised the crimes of bloodshed to a figure quite appalling.

Dr. Horace T. Hanks, of New York, writes to the *Medical Record*: "I have found, formerly, much difficulty in keeping my needles always free from rust and sepsis. For a year, however, I have kept all my needles in pure 'lysol,' and am perfectly satisfied with the result. I place from thirty to

fifty assorted needles, points upward, in a suitable small bottle—large mouth, and screw-top preferable—and then fill with lysol. When needles are to be used turn the lysol into another phial and the needles on to a plate, and select the ones required, returning lysol and needles to the original bottle when through. By this means I always have aseptic needles, free from rust, and a small bottle of germicide fluid if no other is at hand."

Dr. Thomas Heazle Parke, a distinguished surgeon, and one of Stanley's most intimate and beloved companions in the latter's trip across Africa in 1887-88-89, is dead. He was an Irishman, his birthplace being Ologher House, Drumona, County Tyrone. Dr. Parke was only thirty-six years old at the time of his death. He was commissioned as surgeon in the medical staff of the British Army in 1881, and from that time onward his life was spent in active service abroad. The following year he was in the Egyptian campaign and received the Queen's medal and the Khedive's star. He then went through the cholera epidemic in 1883, and afterwards was in the Nile campaign for the relief of Gordon. Dr. Parke was present at the battle of Abu Klea, the action of Gubart and at other engagements. He went across the Bayudu Desert and was in medical charge of the naval brigade under Lord Charles Beresford and returned in medical charge of the Guards camel corps under Lord Falmouth. Subsequently he crossed Africa with Stanley in 1887-88-89, and when he returned received many honors from societies, his government and the Khedive.



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### Original Articles.

#### LAWS OF GROWTH OF THE CELL APPLIED TO HUMAN ANATOMY.\*

BY ROBERT REYBURN, A. M., M. D.,  
Professor of Physiology and Clinical Surgery, Medical Department Howard University, Washington, D. C.

The human ovum from which all the tissues and organs of the adult human body are built up is, in the earliest stages of the embryonic life, nothing more than a simple cell or mass of protoplasm.

These masses of protoplasm or cells (which form the ova) are practically identical in all animals, and consist of a fecundated living germ, which has sur-

rounding it a limited supply of food yolk or nourishment. This serves to nourish the embryo, until other structures are developed, which carry on the process of nutrition during the entire period of foetal existence.

As the human ovum or egg is directly transformed during the process of development into the adult human body, it is self obvious that the laws governing the growth of the human ovum must be identical with, and furnish the key to, the laws governing the growth of the organs and structures contained in the human body in its adult or completed form.

What, then, are these laws? Or rather the causes and conditions which modify the growth of cells?

The first of these conditions here to be specified is, that cells grow in size by

\*Read before the Section of Anatomy, Pan-American Medical Congress, September 6, 1893.

layers of nutriment applied on the outer surfaces of the cells. This is always accompanied by a nearly equivalent amount of waste material absorbed from their inner surfaces. So long as the amount of nutritive material absorbed and deposited upon the outer surfaces of the cells is greater than the waste from their inner surfaces, the cells continue to grow and increase in size until the time of maturity is reached.

Just at this point the forces of waste and destructive assimilation are balanced by the powers of the organism to absorb and assimilate nutriment.

After the period of maturity has been reached the retrograde process begins. The individual cells and in consequence the body as a whole, gradually cease to absorb and assimilate as much of nutritive material as is required to supply the waste, hence the inevitable result is death, the great and pitiless law that rules the organic world.

How then does the human body as a whole grow from infancy to maturity? Precisely as the individual cells of the body do.

Take, for instance, the development of the great arterial trunk of the body, the aorta. In the new-born child the aorta is a small tube, the lumen of which will measure perhaps three-eighths of an inch across; when this same child shall have reached adult manhood his aorta will have become a great tube an inch or more in diameter.

This increase in size, it is very evident, must have been produced in the way above described. As years pass on, numberless layers of microscopic tenuity have been piled upon the outer surface of the aorta, thus increasing the thickness of its walls. Along, and indeed

simultaneously with this process, goes on the absorption and waste from the inner surface of the blood-vessel, in this way increasing its internal dimensions. This same law is applicable to the growth and development of the intestinal canal with the stomach and accessory organs of digestion to the development of the Haversian canals and medullary cavities of bone to the growth of the shafts of the long bones of the extremities, and the growth of the limbs. Not only is this law of growth true of every organ and structure found in the body, but it is just as truly applicable to the growth of the human body as a whole.

The second of these causes which modify the shape of living is their tendency to grow in the direction in which they can find the most abundant supply of nutriment. Living cells, when found free or floating in the liquids of the body, are always found to be circular in shape. As found in other parts of the body they vary greatly in form and size. Take, for instance the lacunæ or bone cells as found in human bones; these were originally circular or ovoidal cells; as the process of transformation of cartilage into bone goes on, the cells become incased by layers of earthy matter surrounding them. This would prevent the possibility of their absorbing sufficient pabulum to provide for their nourishment; in order to overcome this difficulty the cell in its process of growth absorbs certain portions of the earthy walls enclosing them, and thus the myriads of canaliculi or fine tubes which connect the bone cells and the Haversian canals are formed. The canaliculi are of course too fine to admit the passage of the red or white corpuscles of the

blood, and their nourishment is carried on by the liquid plasma.

Many illustrations of this second law are to be met with in the body; it is only necessary here to mention the rapid repair of fractures of the long bones of the body, when the fracture occurs just below the point where the nutrient artery enters the bone, as compared with the slowness of repair when it occurs just above, thus partially cutting off the circulation of the blood in the part.

The more perfect ossification of the bones of the cranium, as compared with the other bones of the body of the newborn child, is probably due to the position of the fœtus, which usually lies suspended with the head downwards in the uterine cavity.

In fact, it is generally admitted that the growth and development of every tissue and organ in the body is directly proportioned to the amount of the blood supply.

The third cause modifying the form of the cells is that each cell, under favorable conditions, tends to reproduce the same type of parent cell from which it sprang. Bone tends to reproduce bone, muscle reproduces muscle, and so in like manner do all the tissues and organs of the body. In pathological growths we do find alien and foreign tissues in the diseased parts of the body. Bone, for instance, is often developed in epidermoid cysts, and in parts of the body which in health are composed of cartilage and muscle.

One important fact, however, is to be noted in studying the constituents of pathological growths, and that is that all growths are histologically true to the kind of tissues which are formed by the

layer of the embryo from which they originally came. As is well known, the human embryo primarily divides into two layers, the ectoderm or epiblast and the endoderm or hypoblast. A third layer is afterwards developed between these, which is called the mezoderm or mezoblast. Tissues therefore which originally sprang from the ectoderm or endoderm layer of the embryo do not either in normal or pathological growths tend to reproduce the tissues which were originally formed from the mezoderm or middle layer of the embryo.

The fourth cause modifying the shape of organic forms is the pressure of other cells upon them during their earlier period of development. The flattened shape of the cells found in the epidermis, in the hair and many other parts of the body, is evidently due to this cause, and the same result is seen from pressure in the multiform shapes of the cells of the tissue invaded by cancerous tumors.

So numerous are the instances to be found in the body of these changes of shape produced by pressure, that it is unnecessary further to dwell upon them.

After maturity the retrogressive change or metamorphosis immediately begins in the tissues of the body, the powers of assimilation of nutriment become gradually insufficient to keep up with the waste of all the structures of the organism, and hence the body as a whole tends to emaciate. Not only is this the case, but the power of the individual cells to separate the waste material which is formed as the result of their nutrition becomes impaired. These waste materials as a consequence accumulate, and cause thickening of the cell walls of all



parts of the body. One of the most striking of the results of this process is to be seen in the hardening and calcification of the arteries which is so commonly found in persons of advanced age. The tissues themselves tend to degenerate in old persons. Muscle becomes degraded into fat, and the same process invades all the connective and other tissues of the body; a familiar example of this is seen in the arcus senilis or fatty degeneration of the cornea, which is one of the surest signs of the aging of the tissues.

It may perhaps seem necessary to apologize for presenting to the readers of the JOURNAL such an elementary sketch of the growth and development of the human body, yet it is a necessary preliminary to my chief object, which is to call attention to what I believe to be our unscientific method of teaching human anatomy.

The ordinary way of teaching human anatomy in our medical schools and colleges is to begin by teaching studying the bony framework of the adult human body. This has always seemed to me to be an entirely erroneous method, for it adds unnecessary complexity to the study and prevents the student from grasping the real simplicity of the idea of man's structure, when it is studied from the point of view of its being simply a development of the human ovum.

If we take up the study of chemistry, for instance, we never begin by studying the more complex compounds first; on the contrary, we first master the elements out of which the complex bodies are formed, and thus proceed from simplicity to complexity.

This same statement is true if we take

up the studies of botany, mineralogy, geology, or in fact any of the branches of the natural sciences.

Why, then, do we adopt a different study of human anatomy from the one we use in the study of all the other branches of natural science?

My idea, then, of the true way to teach human anatomy would be to begin by demonstrating the human ovum or cell, then the fluids, such as the blood and lymph in which the cells are found free and floating. After this, study the changes produced in the ovum by impregnation, the segmentation of the ovum with the development of the blastodermic membrane, and its further division into its external and internal layers.

Study, then, the tissues and organs formed from these layers in their order of development, then take up the study of the development of the third layer of the embryo, with the organs and tissues formed from it. The study of human anatomy carried on by this method gives to it a simplicity and beauty that renders it worthy of being numbered among the exact sciences.

It may be here remarked that this method is not a new or untried one, for several years Professor Piersol, of the University of Pennsylvania, has taught anatomy by a method similar to the one above mentioned, and the writer a number of years ago, when teaching anatomy in the Medical Department, Georgetown University, adopted with success the same plan.

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Dr. S. B. Bond has removed to 23 W. Chase Street, between Cathedral and Charles Streets.

EMERGENCY SURGERY.\*

BY I. R. TRIMBLE, M. D.,

Surgeon Baltimore & Ohio Railroad Co.; Surgeon Baltimore & Lehigh R. R.; Lecturer on Clinical Surgery at the University of Maryland; Professor of Anatomy and Clinical Surgery at Woman's Medical College of Baltimore.

Mr. President and Gentlemen:—I will begin my remarks by quoting a part of the yearly report of the B. & O. E. R. D., which was sent by our Chief Surgeon, Dr. L. McLane Tiffany, to President C. F. Mayer, on July 1, 1893.

"Superintendent Barr has furnished the following statistics at my request:

"Average Relief membership during the year, 23,235; Cases of accidental deaths, 98; Cases of accidental injury, 5,501; Number of injured per thousand, 236, or nearly one in every four.

"Comparing this with the statistics of well known battles, it is found that at the first battle of Bull Run 3,244 in the Federal and Confederate forces were killed and wounded. 30,000 Federal troops besieged and after several days of fighting captured Fort Donelson; the killed and wounded numbered 2,185, or 73 per thousand. At the battle of Fair Oaks about the same number of Federal troops were engaged as there are members of the Relief Department. Of these 1,111 were killed and wounded, being about 50 per thousand, or about one in twenty. The hazardous nature of the employee's occupation is at once apparent.

"The company's surgeons treated 203 persons, not employees, who were injured on the company's property: passengers, tramps, etc.

"During the year the company employed 235 surgeons, who are located at convenient points, averaging about ten miles distant from one another."

The percentage of trainmen killed is as follows:  $5\frac{1}{2}$  per cent. of all trainmen killed are conductors,  $10\frac{1}{2}$  per cent. of all the trainmen killed are enginemen,  $12\frac{1}{2}$  per cent. of all the trainmen killed are firemen, 72 per cent. of all the trainmen killed are brakemen.

The life of a brakemen you can see is very short.

We can liken our 23,235 Relief men to a standing army in active service.

During the past year there were killed and injured of this number 5,599 persons.

We 235 Relief surgeons are in the field and on active duty day and night and we are a very important part of the great B. & O. system.

The Relief Department says to these men, "You must, when injured, have our Relief surgeons to attend you, or you can get another surgeon and pay him yourself."

This being the case, every surgeon in the B. & O. Employees' Relief Department must be ready and able, at all times, to give prompt, comprehensive and the best surgical knowledge and treatment to the men as they would be capable of getting anywhere in the world. For if we fail in this, the B. & O. E. R. D. is not doing its duty by its members, and also leaves the company liable for damages.

Every day that an injured employee is off means pecuniary loss to the man, as well as to the Relief Department. It remains with the surgeons of the road to bring this loss to the minimum.

\*Read before the State Association of Railway Surgeons of West Va., at Moundsville, W. Va., August 26, 1893.

Every injury stands upon its own merit and I can only give the general outline of the treatment which we have found by experience to give the best results. In railroad injuries the violence is generally crushing. The body producing the wound is septic. All wounds then, when there is an abrasion of the cuticle, are septic.

Our aim in all cases is to get the patient well in the shortest space of time with the least possible discomfort and systemic disturbance, and that the injured part may resume its normal use.

To do this the wound must first be gotten clean—as surgically clean as is possible.

Now to clean a wound having dirt and grease ground into the lacerated skin and tissue is seldom possible without an anæsthetic.

For cleansing a wound we have a stiff nail brush with a free supply of hot water and soap; and the surface of the skin and lacerated tissue must be vigorously scrubbed until all particles of foreign matter have been removed. The cost of these hand scrubs are only four cents apiece.

Turpentine removes the grease better than soap; but after the use of turpentine the parts must be freely washed with water, as there will be much smarting from the turpentine left on the wound.

A clean lacerated wound heals promptly with little or no inflammatory reaction.

Pus in the wound may mean the loss of a life from septic poisoning; or the loss of a limb or part of a limb; or the tying up of the tendons by inflammatory exudation; or by sloughing of the tendons,

thereby rendering the limb practically useless.

The monuments of such surgery are too often seen. The best dressing for a wound, until the surgeon is ready to clean it properly, is to bind it up with a large pad of absorbent cotton until ready for the first dressing, and it is this first dressing that we depend on for our clean work.

The exploring of the already septic wound by a surgeon before he has thoroughly cleansed his hands, or with septic instruments, is little less than criminal. For a while the patient may escape with his life from the former; he will not escape from the septic surgeon.

Cleanse the most trivial wounds as thoroughly as the graver ones. I saw an instance of such carelessness only a few weeks ago. A brakeman had a compound fracture of his right ring and middle fingers. He went to a doctor, who, without the least seeming attempt to cleanse the hand, smeared some salve over the wound and bound up the hand.

I saw him thirty-six hours after the first dressing; temperature 104, pulse 120. Erysipelas, both superficial and deep, of hand and forearm.

The ultimate result was the loss of both fingers and a useless hand from sloughing of the other tendons.

This man gained his livelihood by his hands—now he will have to remain, the rest of his life, in some minor position, with hardly a chance of promotion.

A surgeon should never examine a patient superficially, for while the patient may express himself as feeling well, he



can at the same time be seriously injured.

Such a case was sent me from Washington last spring, with the following history:—The man had been caught between the tops of two cars and rolled. He fell to the ground, got up and walked to the station and asked to be sent home to Baltimore. A surgeon in Washington saw him and said he was only squeezed and would be out in a few days. I met the train and the man was on a cot in the baggage car. He said he had no pain, but wanted to make water and had attempted to make water in Washington, but failed, only a few drops of blood coming from his urethra. I told him he must go to the hospital, for I feared some bladder injury; on examination at the hospital, when an attempt was made to introduce a catheter into the bladder, it went into a free space. By a finger in the rectum the urethra was found to be severed from the neck of the bladder. A perineal section was at once performed. The urethra and bladder had been separated by the pubic bone, which had been broken on the right side; this had severed the urethra from the bladder and also cut through the walls of the bladder in two places.

The incision was extended to the left as in a perineal cystotomy and the bladder was freely opened, so there would be no accumulation of urine, either in the bladder or connective tissue around the bladder or in the connective tissue between the bladder and skin.

Never make the mistake of not cutting freely; and always leave an opening at the bottom of a septic wound, for drainage.

This man made a good recovery and has returned to work.

The essentials then for clean surgery are that the surgeon must first cleanse himself before he attempts to clean the septic wound. His instruments must be aseptic. He must have a nail brush, soap, hot water and a razor, for all hairy surfaces must be shaved, otherwise they cannot be thoroughly cleaned.

The surgeon cannot thoroughly cleanse the wound and give the anæsthetic; he must have an assistant.

The use of antiseptics before a wound is clean are absolutely useless.

After cleansing the wound, it can be washed off in a hot bichloride solution, 1-3000.

The vessels, when necessary, are tied with sterilized silk and the edges of the wound brought very loosely together with sterilized silksutures, plenty of outlet being left for oozing. Sterilized gauze applied to the surface and a pad of sterilized absorbent cotton, with common cotton and a baudage, are the dressing we use.

Iodoform, aristol, iodol, salves, etc., can be discarded as useless in acute surgery and should never be used, except at times on burnt surfaces.

We want the simplest and best methods of treatment, and all additions of foreign material to the wound are to be omitted.

All germs are killed after 90 minutes' exposure in a closed vessel, in which steam is being generated—it is not necessary to have an elaborate steam sterilizer—any vessel which has a top to it and in which water can be boiled will answer the purpose.

The common kitchen clothes-boiler, with a tray in it to keep the things to be sterilized above the water, is always to be had.

The way we prepare our silk, gauze and cotton, is as follows: Wind the silk on cotton, and put in a small vial, stopping the mouth of the same with cotton.

Gauze cut in suitable lengths is wrapped in cotton. Absorbent cotton and the gauze is then rolled up in a piece of cotton flannel and securely pinned.

The vial of silk and cotton flannel bundle are then put in the sterilizer and subjected to the steam vapor for the length of time required to kill all germs.

Vials of silk and bundles of gauze and cotton are kept always on hand and ready for emergency.

Instruments which have been handled or taken from a pocket case should be boiled in water for 20 minutes before use.

During the operation we do not irrigate or sponge with wet cotton. Dry sterilized cotton is used for sponging.

The injury produced by rapidly moving large bodies is far-reaching; as a consequence the shock is greater and will differ from surgery in which we have prepared the patient for days before the operation. The patient has received a severe shock before we see him and we must not increase that shock if it can be avoided.

When we are ready to operate, the patient is to be covered with a sterilized sheet or towels or in a bichloride sheet or towels.

Let no one touch the wound or handle the instruments or dressing unless they are surgically clean. By so doing, as clean surgery can be done in the meanest hovel as in the best hospital.

The treatment of burns and scalds

should be handled as any other wound, but some cases will require an application of oil and lime water or some other materials to the surface.

In serious injuries, our attention is directed to the support of the patient and overcoming shock and collapse.

Convey the patient to some protected place, wrap up well, apply hot bottles to the surface, give small doses of warm coffee or some warm stimulant.

If there is much shock, the liquids taken into the stomach are not absorbed, and only help to deepen the shock by the reflex irritation of the pneumogastric nerve.

Hypodermics of whiskey, small hypodermic doses of morphine, are given, but, best of all, hypodermics of 1-30 grain of sulphate of strychnia every twenty minutes, until some systematic effect is produced, is our most valuable remedy.

Hypodermics of 1-100 grain of nitroglycerine or the same amount put on the mucous membrane of the mouth will be rapidly absorbed and found to be of great service. This dose can be repeated every hour if necessary.

Now comes the question of amputation and when is the best time and with the least increase of shock to the patient. As a rule, primary amputations are best borne after the use of stimulants.

Get the patient as clean as possible before giving the anæsthetic. Explain the possibilities of the injury to the patient and get his consent to do what is, in your judgment, necessary; so that the one anæsthetic will be sufficient.

In injuries in which the connective tissue between the muscles has been disorganized, the amputation should be through sound tissue.

When conservative surgery is attempted, a careful watch of the injured limb must be kept up. A hot bichloride bath or application of hot bichloride towels is the best dressing until we decide what is best to be done.

After amputation, nursing is what brings our patient around; therefore the hospital is the place for all serious injuries. For competent surgeons and nurses are at hand for whatever may arise.

Ether is preferable to chloroform as an anæsthetic. When we amputate or dress a wound, three things are to be observed: 1. The minimum amount of anæsthetic is to be given. 2. The prevention of but the loss of the minimum amount of blood during the operation. 3. The minimum amount of time in operating. These three points must always be carried out.

### THE TREATMENT OF POTT'S DISEASE OF THE SPINE.\*

BY A. B. JUDSON, M. D.,

Orthopædic Surgeon to the Out-Patient Department  
of the New York Hospital.

While caries of any part of the vertebral column cannot be considered an unimportant affection, it is well to recognize the fact that much depends on the region of the spine involved. In the middle dorsal region it is perhaps the most serious trouble, excepting malignant disease, that can attack the bones of the growing child. In this part of the spinal column the destruction is often extreme and the deformity great, evidently because the affected bones are at

the greatest disadvantage mechanically. Lower down the vertebral bodies are so large that they do not lose their relation of mutual support until the loss of substance is very extensive, and above the vertebral bodies, though small, have less weight to sustain. But in the immediate portion not only do the bones feel the incessant movements of respirations, but they are also more widely moved in flexion and extension and in lateral curving with rotation than in other parts of the column, and furthermore, they are exposed in a peculiar manner to the risk of over-strain from their position in the middle of the column. I think it is in the experience of all of us that in this middle and upper dorsal region Pott's disease continues longest before consolidation takes place.

Here we have a most striking illustration of the fact that the recovery from articular osteitis is postponed by unfavorable mechanical environment. As joints in the upper extremity, free from the mechanical stress attending locomotion, recover easily, while those which, in the lower extremity, bear the heat and burden of the day, recover only after prolonged and extensive destruction, so articular ostitis in the cervical region of the spine is easily curable while in the upper and middle dorsal region; relief and repair come only after desperate and prolonged risk.

How can we best assist nature to cure this disease in this difficult part of the skeleton? The same general rules apply here as in the treatment of articular osteitis in the lower extremities. We can not cut short the disease by an operation or by any procedure whatever, but can expect with confidence, and must pro-

\*Presented at the Pan-American Medical Congress at Washington, September, 1893.



mote by our best endeavors, the arrest of destruction and the beginning of repair. What, then, can we do to put the affected vertebræ in their best attitude and to raise the defensive and reparative powers of the system to their highest efficiency? As in articular osteitis occurring elsewhere we desire (1) to relieve the bone of the duty of supporting weight and concussion and (2) to prevent the affected joint from motion, believing that the arrest of these two functions, weight-bearing and motion, are essential to good treatment. It does not seem wise to keep the patient recumbent for the long period necessary. In the management of hip disease we put the affected limb to bed, so to speak, while the patient is up and about. But a similar resort in Pott's disease is impossible. Since the patient must be up and to a certain extent active in locomotion, our best resort in my opinion is to take what benefit can be had from the application of a lever making pressure from behind forwards in the neighborhood of the posterior projection and counter-pressure from before backwards at two points, one above and the other below the level of the seat of the disease. In a limited sense this application relieves the diseased joints from the weight of the body, while the patient is up and about, because antero-posterior pressure thus applied transfers a part of the weight and concussion incident to standing and walking from the diseased bodies of the vertebræ to the processes, which remain sound. Having thus (1) removed so far as is practicable injurious pressure from the diseased structures it is obvious that we have also applied the most effective kind of retentive splint for (2) the arrest of motion in the affected joints.

It does not take much practical experience to convince one that efficient pressure applied in this manner is productive of good. It may not at once arrest morbid action and induce cicatrization of the carious bone. For these events we must wait for the natural reaction, but it is not difficult to believe that nature will the more promptly intervene with reparative efforts if our mechanical applications relieve distress and substitute a feeling of strength for weakness and apprehension. A well-applied support at once gives a degree of relief which finds plain expression in the face and attitude of the patient. As a matter of fact a feeling of security and comfort is afforded by the use of a corset made from any of the materials in ordinary use. I will not indicate the defects of apparatus of this kind. The inexpensiveness of jackets and the ease with which they can be obtained and applied make them of the greatest service to a vast number of patients who otherwise would have no mechanical support whatever. But when and where it can be done it is necessary to give the patient the benefit of accurately adjusted antero-posterior pressure.

At the best, antero-posterior pressure, no matter how carefully applied, fails to give all the support which is desirable. This is because the leverage is deficient.

In the vertebral column there is found no long bony lever such as is at hand in making a mechanical application for fixing the knee. There is, rather, a succession of irregular bones movable upon each other, which, from the nature of the case, impair the success of any attempt to arrest motion or support the column by pressure from behind forwards and counter-pressure from be-

fore backwards, because the pressure from before backwards will, a part of it at least, be expended in bending backward portions of the vertebral column above and below the projection. The force thus employed is, however, by no means wasted, as it secures an ultimate improvement in the shape of the trunk which is often characteristic of patients who have been thus treated.

The apparatus needed is essentially simple, consisting of two parallel uprights united below by a pelvic band and diverging at their upper ends at the base of the neck, and curving over the tops of the shoulders. Pressure from behind forwards is made by two pads attached to the uprights at the level of the projection and applied a short distance from the median line on each side. Counter-pressure from before backwards is made below by a strap passing from one end of the pelvis and above by straps, one on each side, passing from the upper end of the upright through the axilla to be buckled to the upright. The most important feature of a brace constructed to carry out these views is the use of mild steel for all the metal parts. The use of this material puts in the hand of the surgeon the power to modify the degree and direction of pressure to the changingshape and to meet the increasing tolerance of the skin to pressure. The reaction of the skin should receive special and constant attention and gentle and gradually increasing pressure should be made till the limit of comfortable tolerance is reached.

By patient attention to details, apparatus thus designed may with certainty be made comfortable and efficient. The diffused support furnished by a jacket is

often secured by the addition, to the simple lever described above, of aprons and other pieces which add to the feeling of stability and security without interfering with the chief function of the apparatus, which is to make antero-posterior pressure. One hardly knows where to begin and where to end in the consideration of the details which demand attention in practice of this kind. I will close by saying that cheapness and cleanliness may be promoted by leaving the steel parts of this brace unpolished and covering them with a single layer of adhesive plaster, and then with strips of cotton flannel or silk cut bias, and renewed without much trouble as often as may be desired.

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About October 15th, a Medical Directory of the State of Connecticut will be issued by the Danbury Medical Printing Co., of Danbury, Conn. It will contain a list of all the medical practitioners of the State, the various medical societies, all the dentists and dental societies, druggist and pharmaceutical societies, nurses and training schools for nurses, hospitals, etc. Price \$1, delivered free by post.

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The Hospital Accommodations of our Great Cities.—New York has 11,000 hospital beds; Philadelphia, 6,391; Chicago, 4,684; Cincinnati, 3,000; St. Louis, 2,086; Brooklyn, 2,000; Buffalo, 1,025; Denver, 961; St. Joseph, 849; Detroit, 672; Milwaukee, 667; Omaha, 617; St. Paul, 522; Kansas City, 516; Albany, 447; and Minneapolis, 325.  
—*Medical Record.*

## MARYLAND MEDICAL JOURNAL,

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*Subscription \$3.00 per annum, payable in advance.*

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BALTIMORE, OCTOBER 7, 1893.

**Editorial.**

## HYDROCYSTOMA.

An illustrated paper upon this subject is to be found in the *Journal of Cutaneous and Genito-Urinary Diseases*, August, from the pen of Dr. Robinson, of New York; and as the general practitioner should know something of such skin phenomena we give a brief epitome of Dr. Robinson's observations.

The lesions, which are found chiefly upon the faces of washwomen, who sweat freely and expose the face much to warm vapor, are somewhat similar to malaria and sudamina; but are of large size, presenting the appearance of tense, clear, shiny vesicles, generally round or ovoid in outline and varying in size from that of a pinhead to that of a split pea.

The larger lesions sometimes have a darkish blue tint, most marked at their periphery. Lesions as they dry up have a whitish appearance. There are no

signs of inflammation in the affected region; though in severe cases a mild hyperæmia is observed. There are no subjective sensations save occasionally a slight sensation of tension or smarting. If the vesicles are ruptured the contents are found to be always slightly acid.

The cases are worse in summer than in winter. The eruption usually appears on the lower part of the forehead, the orbital region, the nose, the cheeks and often the upper and lower lips and the chin. Perhaps one hundred or two hundred lesions in all are present.

The lesion is a cyst, but not a pure sweat-retention cyst. It has no connection apparently with dyshydrosis.

## BALTIMORE AS AN EDUCATIONAL CENTER.

The phenomenal development of Baltimore as a commercial and manufacturing center during the past five years is no less remarkable than her growth as an educational center.

The establishment of the Johns Hopkins University, no doubt, led the way to the growth of other institutions of learning by the stimulus which her broad and advanced position suggested and by the encouragement which her success imparted.

The Hopkins was an objective lesson which other institutions recognized as the basis upon which success could be safely calculated. Her policy destroyed all precedent in this community and at once demonstrated that work and progress were the elements of growth and success. Young, vigorous and broad in her lines of work, students from all



parts of the country were attracted to her halls.

The students were quick to see the advantages which were presented to them. The opportunities for the broadest culture were presented side by side with those features of climate, hospitality, social life and cheapness of living which no other city in this country could more liberally offer. This combination was a rare one and it has solved the problem as to the future growth of Baltimore as an educational center. The Hopkins had scarcely demonstrated the advantages of our city when the Woman's College opened her doors, and by marvelous energy and push forged to the front rank of educational institutions for the fair sex.

The medical schools of Baltimore were next in line to take up the wheels of progress and demonstrate the facilities which could here be offered for the education of medical men. Two decades ago it was a rare thing to find a medical student in this city claiming residence in a Northern or Western State. Baltimore relied almost entirely upon Maryland and Virginia, North and South Carolina for her medical classes. This policy has been changed to such an extent that an examination of the catalogues of the medical schools of the city will show from ten to thirty per cent. of northern and western students.

The meaning of this is significant and admits of a much broader and more liberal interpretation than has been assigned—that their students have been attracted here by the ease and cheapness with which a medical education may be obtained.

Facts are stubborn things, and one

fact is apparent. The bid for students has not only brought the student, but the student has quickened and reinvigorated every medical school in Baltimore. There is not a medical school in the city that has not realized the significance of the movement in this direction and quickened its pace to meet the requirements of this condition of affairs. Thousands of dollars have been invested in buildings or in improving medical colleges and hospitals, the vast bulk of which has come out of the pockets of the men engaged in medical teaching.

The older medical schools of the city have led the way and the younger institutions have fallen into line and forged to the front.

The three-year graded course has been accepted by all. Histological, pathological and chemical laboratories, are the accepted order of the day. Hospitals and lying-in institutions have kept pace with the demand for clinical work.

We can mention no feature of medical instruction which the schools of this city have not incorporated in their curriculum. All of this speaks well for the medical schools of Baltimore, and it speaks volumes for the future progress of the city as a medical center.

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#### RETIREMENT OF DR. A. K. BOND FROM THE EDITORSHIP OF THE JOURNAL.

Owing to the demands of his private interests, Dr. Bond has resigned the editorial management of the JOURNAL. He has conducted the editorial department since May, 1891, and his labors in the interests of the JOURNAL have been honest, conscientious and earnest. The duties

of an editor are by no means easy, the editorial office is not a sinecure, his labors are responsible and exacting, the effort to please a large and critical audience is both difficult and trying. Dr. Bond has discharged his duties with patience and fidelity and with a sincere desire to promote the welfare of the profession and also of the JOURNAL.

The readers of the JOURNAL will no doubt share with its proprietors a high sense of appreciation of the work which Dr. Bond has done for the cause of medical journalism in Maryland.

#### THE MEDICAL SOCIETY OF VIRGINIA.

The annual meeting of the Medical Society of Virginia was held in Charlottesville on Tuesday, Wednesday and Thursday of this week, and was not only largely attended by members, but there were a number of distinguished visitors from a distance. The work done by this society is of the highest order and its organization is a model for similar societies. In addition to an unusually large list of active members now on its rolls, a large addition of new members was made at this meeting. The State Board of Medical Examiners, under the authority of this Society, has given a tone and standing to the profession in the State not surpassed by any other State in the Union. The good work of a Law to Regulate the Practice of Medicine in a State is fully illustrated by the work of the Virginia law in its influence upon the profession.

The social features of the meeting were of an enjoyable character and the meeting passes into history as one of the most

successful in the annals of the Society. Great credit is due to its able and energetic secretary, Dr. L. B. Edwards, for the success which attends the annual meetings of the Society.

#### THE SEMI-ANNUAL MEETING OF THE STATE FACULTY.

The next semi-annual meeting of the Medical and Chirurgical Faculty of Maryland will be held in Annapolis on the third Tuesday and Wednesday in November. This meeting promises, at this time, to be one of the most successful of the semi annual meetings.

The Faculty was invited to hold this meeting in Annapolis by the Anne Arundel County Medical Society, which, though recently organized, has a large and active membership, and is working hard to show the Faculty what the work of organization can do, when earnest and willing hands and hearts engage in a good cause. The profession of Anne Arundel can be relied on to do their duty. We ask on behalf of the committee of arrangements the aid of the members of the Faculty in the scientific work of the meeting. Any member wishing to read a paper before the meeting is requested to send the title of the same to Dr. T. A. Ashby, Chairman, by November 1st.

#### Reviews, Books and Pamphlets.

*The Theory and Practice of Medicine; Prepared for Students and Practitioners; by JAMES T. WHITTAKER, M. D., LL. D., Professor of the Theory and Practice of Medicine in the Med-*

ical College of Ohio; Lecturer on Clinical Medicine at the Good Samaritan Hospital; Fellow of the College of Physicians of Philadelphia; Member of the Association of American Physicians, of the American Academy of Medicine, and of the American Medical Association. With a Chromo-Lithographic Plate and three hundred Engravings. Octavo, 840 pages; Extra muslin, price, \$5.75; leather, price, \$6.50. New York: William Wood & Company.

The very handsome volume before us presents the diseases belonging to the department of Medicine from the standpoint of modern science. Bedside difficulties which so sorely puzzle the practitioner are subordinated to the more scientific aspects of the disease. The author appears pre-eminently as a medical bacteriologist; yet his directions for treatment are practical and wise. To the physician already equipped with the many-sided knowledge of the sick man which comes from long experience at the bedside, we would especially recommend this volume as an exponent of recent scientific progress.

*Heath's Practical Anatomy*; A manual of Dissections; 8th edition. Edited by Wm. Anderson, F. R. C. S., Surgeon and Lecturer on Anatomy at St. Thomas's Hospital, etc.; with 329 Engravings on wood. Philadelphia: P. Blakiston Son & Co., 1012 Walnut St. 1893. Cloth, pages 744. Price \$5.

The number of editions of this attractive little book attests its suitability to the needs of the medical student. We are in every way pleased with it and

recommend it to the inspection of our readers.

*Recent Development of Massage*; by Douglas Graham, M. D., Boston, Mass.; Fellow of Massachusetts Medical Society, etc.; 2nd edition, 1893: George S. Davis, publisher, Detroit, Michigan. Paper, price 25 and 50 cents.

This is one of the Physician's Leisure Library Series for 1892.

Beginning with a few pages upon the history of massage, and its physiological influence upon the muscles, the author proceeds to discuss its practical application in various abnormal states of the general system, the digestive organs, the joints and muscles, curvature of the spine, chronic ulcers, incontinence of urine in females, diseases of the eyes, etc.

### Correspondence.

*Editor of Maryland Medical Journal:*

DEAR SIR: An editorial notice of the Woman's Medical College of Baltimore in your issue of August 12th, although conceived in the kindest spirit and otherwise very correct and flattering, is calculated to create a false impression in one particular and seems to me therefore to call for this notice. In saying "the college has adopted the three-year graded course of instruction," you imply by the use of the "present perfect" tense, (as grammarians now call it) that the change has just been made. This would also be the inference from the fact that your article seems to be called forth by recent advances in the college, and in enumerating these advances the three-years course seems to be one of them. Now the fact is that the college has prac-



tically required the three-year course since the session of 1883-4; for in the latter year it refused to admit anyone to the ordinary two-year course except upon the presentation of a certificate, the form of which was given in the catalogue, showing that the applicant had previously studied for a period of twelve months under a medical preceptor. No student was ever admitted on this condition, so that I may say we have had the three-year requirement since 1884. In 1889 we did away with this exception, and since that date have enforced the three-year course absolutely and without exception.

This college was the first in Maryland to adopt this requirement and with one exception (so far as I am informed) the first in the south. It was one of the founders of the American Medical College Association, the motive for which originated in its Faculty.

Further: From its establishment in 1882 it has had a seven months' term, and both written and oral examinations; since 1883, it has had an entrance examination and a graded course; since 1884, hygiene and medical jurisprudence have been systematically taught; pharmacy always formed a prominent and practical feature and has counted as other branches in the standing of students; an average of 70 out of a possible 100 has been required not only of graduates but also of students advancing from one class to the next.

From the first year the College has had its own hospital which, though small, furnishes a considerable amount of material, especially in surgery and gynecology. From a very early period we afforded laboratory instruction and

courses were given in histology. Microscopes were procured from Germany and the services of the most competent men available were secured. In this and other respects it has fallen much short of its wishes and aspirations, but, as you say, it has in all things continually sought to elevate the standard of medical education, and has strenuously resisted the tendency to sink into a mere money-making machine.

By recent purchases it has become possessed of valuable grounds and buildings, which will greatly increase its resources and usefulness, and suffice for its purposes for years to come. I do not adduce these facts in any boastful spirit, but I see no reason why the profession should not know them and give us whatever credit is due to us for them. No college can afford complete facilities for instruction without a liberal endowment and until that consummation is secured we must do the best we can, and follow the principle laid down in our motto *indies fieri meliorem*. As long as we act up to this in good faith I think we may justly claim a share of the confidence and approval of the profession. With many thanks for your kind notice,

I am very truly yours,

EUGENE F. CORDELL, M. D.,

Professor of Principles and Practices, Woman's Medical College of Baltimore.

Baltimore, Sept. 15, 1893.

2032 Maryland Ave.

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### Medical Progress.

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#### SIMPLICITY IN SURGERY.

In the Section on Surgery of the Pan-American Congress, Dr. R. W. Johnson,

of this city, read a paper with the above heading.

Simplicity in all surgical operations is the one great thing which all should keep in view. The tendency of the present day appears to be for the majority of surgeons to add something new to an instrument or an extra twist to a suture, upon which he can hang his name. The immortality of any discovery is intensified by its simplicity. A surgeon should be able to devise plans so simple that his operation can, in an emergency, be done in a hovel as well as in the hospital. Do not understand me to say that I would do away with all precautionary measures; on the contrary, I would not sacrifice an ounce of care for a pound of simplicity; but strip all operations of useless, cumbersome frills. We should use home-made appliances wherever we can, and there is nothing so variable as the so-called antiseptic treatment.

Surgical cleanliness is essential. Boiling is a practical germicide, and by placing your instruments, trap and all, in boiling water for a stated period, you render them thoroughly aseptic, and this can be done in any kitchen. A brush and bichloride solution for washing the surrounding parts is all that is necessary. Should you wish to apply an antiseptic dressing, gauze wrung out in bichloride solution will answer nearly all purposes. Then render the hands aseptic and observe all ordinary laws of cleanliness.

*Gun-shot Wounds.*—What better treatment than leave the bullet alone, unless it carries with it some of the clothing or other septic material with it into the wound? I seldom rummage for a bullet

unless complications are present other than the bullet itself.

*Sutures.*—New sutures are brought to our notice, lasting for a few days and then giving way to a newer one or bobbing up under a different name; but the simpler ones still survive.

*Hæmorrhage.*—Various bands and appliances have been and are continually being devised for controlling hæmorrhage, but the Esmarch's band has come to stay, owing to its simplicity.

A TRIBUTE TO THE MEMORY OF  
SURGEON-MAJOR PARKE BY  
MR. STANLEY.

Mr. Stanley writes as follows to the *Lancet*:

We have lost through a sudden and premature death our devoted friend Surgeon-Major Parke. It would be difficult to convey to others what I feel in regard to one who was the soul of good nature and was a treasure of the best qualities which are so conspicuous in a man universally beloved. Personally I am tempted to exclaim with De Tocqueville, "*Depuis longtemps je ne m'attendris pas sur ceux qui meurent,*" and yet, there is only *one* Parke. We should consider ourselves too fortunate altogether if within the brief span of life we could meet with another who exactly filled his place. For it means a great deal more than I need describe. Above all, it means finding one who is true to the core, a very honest and punctiliously honorable gentleman, one made up of sweet simplicity, tenderness and loving sympathy. He was made up of much more which won respect and admiration.

For his own sake I cannot regret his early departure—and for my own sake it is vain.

As a lady who knew him well puts it: "Those who are thus early taken away are surely fitted to be taken. It is best for him. He has escaped this life easily and at once. He had a look in his eyes as of one seeking something in the far distance. There was an unconscious in-born purity and tenderness about him—withal a manliness, a modesty and nobleness of soul that made him stand alone. He has left us in the land of the dying and he is gone to the land of the living. Such is my firm belief."

Some men are great for a stupendous exertion at the trumpet call, and those spirits who are ready to peril life and limb in the performance of a daring task are not scarce, but the man who is such a hive of noble virtues—constant in loveliness as he whose loss this day so many deplore—is rare—most rare. And he was so modest, unobtrusive, quiet yet unshrinking before responsibility, firm in face of peril, a willing volunteer for any good work and yet not aggressive for distinction, that many, like myself, will say we know of none to fill the place Parke filled in our affections and esteem.

#### LARGE DOSES OF DIGITALIS IN CROUPOUS PNEUMONIA.

Mario Bellotti (*Gazz. degli Ospitali*, July 22nd, 1893) treats of the virtues of digitalis in croupous pneumonia, the present paper being a continuation of a similar one published a year ago. His conclusions from a large number of observations on cases in which Fraenkel's diplococcus has been detected are as follows:

(1) All cases of fibrinous pneumonia, due to Fraenkel's bacillus, receive very

great benefit from large doses of infusion of digitalis, always accompanied by milk diet, and occasionally by bleeding. (2) It is necessary to give the digitalis in very large doses, because in pneumonic conditions, both the gastric catarrh which is usually present, and the diminution of HCl of the gastric juice reduce greatly the amount of the drug which actually passes into the portal circulation. (3) Some of the active principles of digitalis seem to exercise a special elective action on the pneumonia toxins, this action taking place chiefly in the liver.—*Brit. Med. Jour.*

#### THE LOCALIZING VALUE OF APHASIA.

Dr. George J. Preston, of this city, read a paper upon this subject at the recent meeting of the American Neurological Association. He called attention to the fact that aphasia has hardly commanded its proper place in the domain of cerebral localization. The centres for the speech processes, and the visual and auditory centres were described. In connection with word-blindness two cases of hemiadopsia were related, one with autopsy, in which there was no word-blindness, as might have been expected. A case of mixed aphasia was related and the brain exhibited. The case showed absolute motor aphasia together with word-blindness, and yet the lesion was confined to the third frontal convulsion; the occipital cortex showing no disease. The general value of speech disturbance, as an aid to localization, especially in disease or injury of the brain, was discussed. A case was reported in which there was a general speech disturbance, with distinct mental



symptoms; patient was at times maniacal. Upon the strength of the general disturbance of the speech processes the skull was trephined over Broca's region and the under surface of the dura found covered with blood. This case was mentioned to show how valuable speech disturbances may be, although very general in nature and not belonging to any recognized variety of aphasia.

#### CREAMERIES AND ENTERIC FEVER.

Dr. Welphy, of Bandon, has done good service in drawing attention to a new mode of diffusion of typhoid infection. Modern dairy farming involves the co-operative use of creameries, where the milk from many farms is separated, the cream being made into butter, and the skim milk usually returned to the farmers. A whole district is thus brought into intimate relationship, and if a farm happens to be affected with enteric fever, and its milk supply implicated, the disease may easily become widespread among the other uses of the creamery, this institution acting as a diffusion centre for a large country population much as a public water supply may in a town. In the particular case in point it seems that a few cases of fever occurred on a dairy farm not far from the town, the disease having probably been introduced from Cork, where one of the patients had been staying. The milk was sent to the creamery, from which, after the process of separation, it was sent to various parts of the country, and thus spread the disease. As soon as the cause of the epidemic was detected, the proprietors of the creamery ceased taking milk from the farmers whose houses were affected. Dr. Browne, of the Local Government Board, has inspected the district, and we understand that he

confirms Dr. Welphy's view of the mode of diffusion of the malady, a mode which it will be well to bear in mind and to guard against wherever this system of dairy farming is in operation.—*British Medical Journal*.

#### Medical Items.

The Anne Arundel County Medical Society, of which Dr. S. H. Anderson is President, held its regular meeting in Annapolis during the present week. This Society is a live and progressive organization and is already doing good work for the profession of Anne Arundel.

Dr. T. E. Murrell, of Little Rock, Arkansas, a graduate of the University of Maryland of the class of 1877, has been elected to the chair of Ophthalmology and Otology in the Barnes Medical College, of St. Louis. Dr. Murrell has been a specialist for many years and ranks among the leading eye and ear surgeons of the south-west.

The Hopkins Medical School opened its doors to medical students on Oct. 2 with a class containing 13 male and 3 female students. As the Hopkins has a four-year graded course, and its requirements are extremely rigid and exacting, this is believed to be a good showing for the school.

The medical schools of Baltimore began their regular winter sessions of lectures on Oct. 2nd. The class of students at each of the schools is, as far as we can learn, fully as large as that of the same date of last year. It is believed that notwithstanding the three-year

graded course and the stringency of the times there will be fully as many medical students in Baltimore this winter as were here last winter.

Dr. R. B. Morison, of this city, was elected President of the American Dermatological Association for the ensuing year at the recent annual meeting held in Milwaukee Wis., Sept. 5th and 6th.

Dr. Morison is recognized here, where he is well-known to the profession, as an eminent authority on dermatological subjects. The honor conferred upon him is well-merited and a just recognition of his work and success in this special line of study and practice.

The Philadelphia Polyclinic will devote a special week, beginning October 30th, to cataract. Operations will be done according to the different methods preferred, by Professors Harlan, Jackson, Risley, and deSchweinitz, and the whole subject including, points of etiology, diagnosis, and the dressing and after-treatment, will be gone over. In addition to the clinics, demonstrations, and practice of operations on the eyes of lower animals, there will be a series of clinical "conferences," participated in by the professors and members of the class.

Notorious examples of the failure of mechanical ventilation by impulsion, or artificially forcing air in a building, are the new London Law Courts and Houses of Parliament, where mechanical arrangements are employed, and all that money and the highest scientific and engineering skill could do to make the ventilation satisfactory has been tried, but without success. Mechanical ventilation by impulsion forces air into a

building under pressure, and at a high velocity, destructive of diffusion, causing disagreeable and dangerous draughts in the vicinity in the line of the inlets and outlets, the other parts of the building being left wholly unventilated, as the incoming columns of air usually travel, are propelled, in a direct line to the nearest outlet, and there make their escape. Engine-driving columns of air through a building is not ventilating it. —From an editorial in the *Sanitarian*.

M. D'Arsonval has proposed to the Academie des Sciences a new plan of treating patients by electricity. The subject is enclosed in a large coil of wire through which alternating currents are passed, and the patient's body thus becomes the seat of alternating induced currents which correspond in frequency with those which circulate in the coil. When rapidly alternating disruptive discharges are passed through the coil, it is possible to demonstrate the presence of the induced currents in the patient by placing an incandescent lamp in circuit between his hands, as it is brought to incandescence, though the patient feels nothing. The influence of the treatment upon the processes of nutrition are considerable, the absorption of oxygen and the elimination of carbonic acid gas being largely increased.—*Ex.*

The treatment of hay fever is subject to criticism such as comes to no other disease, namely, from societies of the sufferers themselves. It is interesting to note that the patients are not as enthusiastic over, and do not report such good results as a society of their medical advisers would be likely to do. The

United States Hay Fever Association have recently held their annual meeting in Bethlehem, N. H., and listened to papers largely on the disease from the patients' point of view. It appears to be the general opinion that the only certain relief is to found in the White Mountains, and that most therapeutic measures are of little or no use, and some of them harmful. The treatment by local cauterization in the nose is often of benefit, but the benefit is generally only partial and temporary.—*Med. Rec.*

In order to serve the best interests of their constantly increasing number of friends in the wholesale and retail drug trade and in the medical profession, and recognizing the unexcelled advantages offered by the metropolis for the prompt and satisfactory disposition of business, Messrs. Sharp & Dohme have removed their general offices from Baltimore to New York. There will be absolutely no change either in the personnel of the firm or the general business policy maintained by them for the past thirty years. Their recently enlarged and completely equipped laboratories will remain in Baltimore, where all matters pertaining to the manufacture and packaging of their products will receive in the future, as in the past, their personal and most careful attention. All orders, remittances, requests for quotations, samples or literature, as well as all general correspondence relative to their business should hereafter be addressed to their general offices at 41 John St., New York.

The Secretary of the Southern Surgical and Gynecological Association, Dr. W. E. B. Davis, of Birmingham, Ala., has started out on his usual active round

of work for the successful meeting of the Association in New Orleans, La., on the 14, 15, and 16th days of November, 1893. This of course means that the prospects are splendid for a successful meeting. Members of the medical profession are cordially invited to attend. Dr. Bedford Brown, of Alexandria, Va., is President of the Association, and the weight of his name, coupled with the renown of the Association as established by his distinguished predecessors and associates who compose the membership, give guarantee that the deliberations of the Sixth Annual Session in New Orleans will have all the importance of a session by eminent authorities. It is earnestly requested that those who may be preparing papers for this session will promptly notify the Secretary, Dr. Davis, in order that the announcement, soon to be issued, will show the value of the papers to be presented and discussed.—*Va. Medical Monthly.*

The *Virginia Medical Monthly* says: That there was a demand by the College of Physicians and Surgeons, Richmond, Va., for this Three Year's Graded Course College in Virginia is evidenced by the number of applicants for matriculation in advance of the opening of the session of 1893-94, on Tuesday, October 3rd. It is confidently believed that, notwithstanding the bad times financially through which the country is passing, the number of matriculates the first year will equal the number in any of the medical institutions of the State since the war. The buildings, at the corner of Clay and 12th Streets, will be ready and the equipments for the several professional chairs are daily arriving. Students should report at the college for



matriculation on Tuesday, October 3rd. The formal opening of the College will be by an address by Professor Thomas J. Moore, at 12 o'clock Wednesday, October 4th, after which hour the curriculum will be regularly carried out. Arrangements have been made for an abundance of clinical material. It is a pleasing fact that a number of the matriculates have been drawn from other States by the esteem in which some of the most prominent of the faculty is held by them and their friends at home. It may be confidently asserted that the success of the College of Physicians and Surgeons, Richmond, Va., is assured.

Dr. William Beverley Towles died about midnight of September 15th, 1893, at his residence at the University of Virginia. The cause of death does not seem to be certain, but the end was hastened by a severe hæmorrhage. Dr. Towles was born at Columbia, Va., March 7, 1847. He received his academic education from the University of Virginia, from which institution also he graduated as Doctor of Medicine in 1869. In 1872, he joined the Medical Society of Virginia, and attended several sessions. On the death of Dr. J. Staige Davis, he was elected Professor of Anatomy and Materia Medica in the University of Virginia, which position he filled with such distinguished ability—especially the chair of Anatomy—as to gain for himself a national reputation as Professor of Anatomy. His services were in demand by other colleges; and, indeed, he served as Professor of Anatomy in the University of Vermont in Burlington for years; his duties in Burlington began each March and continued till the summer vacation, when he returned to the University of Virginia. He was a member of the As-

sociation of American Anatomists, and of the Virginia State Anatomical Board. His popularity with students was always great; in fact, for their medical education many selected the institutions with which he was connected because of the widely known popularity coupled with his well known ability as a teacher of anatomy.—*The Virginia Medical Monthly*.

The Medical Society of Virginia has elected the following officers for the next year: Dr. W. P. McGuire, of Winchester, president; Dr. Robert J. Preston, of Marion, first vice-president; Dr. W. G. Rogers, of Charlottesville, second vice-president; Dr. A. H. Slaughter, of Theological Seminary, third vice-president; Dr. Landon B. Edwards, of Richmond, recording secretary; Dr. J. T. Winn, of Richmond, corresponding secretary; Dr. R. T. Stytt, of Hollins, treasurer; R. S. Marlin, of Stewart, to deliver the annual address to the public and profession in 1894.

Dr. W. L. Robinson, of Richmond, was selected as leader in the discussion of the general subject for the next meeting, which is appendicitis.

Drs. A. S. Preddy, of Keysville; C. M. Blackford, of Lynchburg, and J. D. Moore, Avlett's, were nominated to the Governor to fill vacancies on the Medical Examining Board of Virginia, due to the resignations of Drs. Jacob Michaux, Paulus A. Irving and Hugh M. Taylor, of Richmond.

Dr. R. L. Payne, Jr., of Lexington, N. C., has been awarded the prize of \$100 given by Dr. Hunter McGuire to the Medical Society of Virginia for the encouragement of original work.

The essay this year was on "Obstructions to the Functions of Micturition."

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## Original Articles.

### NOTES ON THE GRIPPE.\*

BY EUGENE F. CORDELL, M. D.,

Professor of Principles and Practice of Medicine,  
Woman's Medical College of Baltimore.

The remarkable epidemic disease known popularly as "the grippe," a term indicating one of its most prominent features, the respiratory difficulty, has prevailed among us for several successive winters and we have accumulated much additional experience regarding its clinical history and treatment. In the following remarks, I propose to consider it briefly from the standpoint of a fairly good personal experience. In passing, I may say that among the numerous arti-

cles which have been written regarding it, those of DaCosta,† J. Mitchell Bruce,‡ and Althaus§ have particularly impressed me. DaCosta, approaching it from the practical side, treats it in the straightforward, common sense style, of which he is master. I heard a distinguished clinician say that his article was the best which had appeared on the subject. Bruce recognizes three varieties of the disease, according as its effects are manifested chiefly on the respiratory, circulatory and nervous systems. In the first variety there are coryza, sore throat, hoarseness, cold in the head, bronchitis, cough, expectoration, congestion or inflammation of the lungs, etc.; in the second, disorders and weakness of the heart and circulation; and in the third, pain, delirium, neuralgia, etc.

Althaus, looking at the matter from

\*Read before the Medical Society of the Woman's Medical College of Baltimore.

† Med. News, 1890. ‡ Lancet, 1891. § Id., 1892.

the neurological point of view, sees only a primary involvement of the great basal nerve centres. This view seems partial and strained and I am not aware that it has obtained any foothold in the profession.

The mention of the types of the disease is indicative of its irregular and erratic character. I would suggest that the second variety of Bruce should be assigned to the nervous class and that there should be another variety for those cases where the stress of the disease falls upon the gastro intestinal system, making thus: 1. catarrhal; 2. nervous; 3. gastro-intestinal; and placing in the latter cases characterized by a heavily-furred tongue, foul breath, anorexia, loss of the sense of taste and smell, nausea, sometimes troublesome vomiting, epigastric pain, sometimes frequent stools with straining and even occasionally bloody discharges.

Of these the catarrhal is the most common variety. In many cases it is masked by the severe pains and extreme weakness, yet a careful examination will almost always elicit some dry and perhaps a few moist bronchitic rales at the base of the chest, or a little redness of the throat, or other evidence, as sneezing, hoarseness, indicating involvement of the respiratory tract. In many cases there is a violent "cold in the head," with profuse nasal discharge. Subacute laryngitis is not uncommon. Congestion of the lung occurs quite often, but genuine lobar pneumonia is very rare. The inflammatory tendency in the lung rarely passes beyond the congestive stage and it usually clears up in 36 to 48 hours, leaving only evidences of bronchitis. Extreme weakness of the heart attends the early stage of some cases.

Robust patients may be seized with unaccountable weakness and faintness; they are scarcely able to breathe, and feel as though they would die. The pulse is frequent, feeble, irregular, often intermittent and there is often a systolic apex murmur, but no evidences of enlargement have been found in my cases. Although the murmur is seated at the apex, it disappears, which seems to indicate a functional character. Remarkable slowness of the pulse characterizes some cases; in one of mine it was 52, in another 42. This occurs only some days after the onset of the disease and after fever has subsided. Severe headache, frontal and bilateral, sometimes through the temples, sometimes also in the occipital region, rarely vertical or over the entire head, is an early symptom. Pain in the back and limbs, and especially in the intercostal spaces, is also common. Very characteristic is a neuralgic pain under the left breast, evidently seated in an intercostal nerve and causing pain in deep breathing and cough. Sometimes the painful spots of Valleix are found along the course of the intercostal nerves. Pain is often the most prominent symptom of the case and is so characteristic of some epidemics as to have led to the idea that the grippe is nothing but Dengue or breakbone fever.

Some of my cases illustrated very forcibly this phase of the disease. For instance, being called in great haste to a man, I found him tossing about on his bed and yelling out with intense pains in the joints and limbs. It was necessary to administer a large hypodermatic injection of morphia and to follow it with full doses of the same and antipyrine in



order to secure relief. In my own first attack of the grippe I had Cheyne-Stokes respiration. It was typical and I laid awake a whole night observing it and thinking how strange it was that I should have it. I have not noticed the report of this symptom by any other observer.

One of my patients suffered for some days with jerking movements of the left arm and very frequent urination, the urine being dark and passed with straining and pain.

Rigors, sometimes a severe chill, attend the inception of the disease and a critical sweat sometimes heralds a convalescence.

An unaccountable difficulty of breathing—a nervous dyspnoea and oppression about the chest—is common.

Albuminuria has been noted by Da Costa and others; it has been very rare in my experience.

I cannot say that I have observed any difference in the disease as it has appeared in the several successive winters, as some claim to have done.

A remarkable feature of the disease is its tendency to recur. A second attack, or more properly, a relapse, is not uncommon about 4 weeks after the primary sickness. This may be quite as severe as the first. I have met with a number of second and even third attacks. One lady had an attack each of three successive winters. I myself had in the winter of 1889-90 a severe primary attack followed by a relapse in four weeks and a third attack in the winter of 1891-2.

The following case I believe to have been due to the same causative agent that produces the grippe.

The latter was prevailing at the time

in several members of the patient's family and a close analysis of the case indicates the presence of symptoms which accompany grippe in its ordinary forms: A young man, æt. 21, a night operator in a telegraph office, was taken ill with severe frontal headache, nausea, constipation, nervousness, restlessness and subsultus tendinum. The next day his neck was stiff and on the second day there was pronounced neck cramp—indicating cerebro-spinal meningitis. His urine was retained and had to be drawn; it was dark, concentrated and contained a large proportion of albumen and a few hyaline and granular casts. There was no hyperæsthesia of the surface or of the spine. For some days he was delirious, slightly strabismic, and had double vision and delusions of sight, imagining that he saw objects about the room, and grasping at them. There was some difficulty in swallowing and the neck cramp became extreme, involving the upper part of the dorsal spine and almost amounting to opisthotonos. His urine was drawn twice daily for six days, after which it began to be passed voluntarily and became more copious and lighter. Meanwhile the albumen and casts disappeared. So serious at one time did his symptoms become, with twitching of the limbs, that I feared impending uræmia (if the condition were not already due solely to that) and gave him infusion of digitalis in full doses but without any evident diuretic effect. I then ordered Clutterbuck's elaterium 1-16 gr. in powder every hour until it began to operate, then discontinuing it. The result was copious watery passages without vomiting or unpleasantly active catharsis, or depressing effect, and marked improvement in the

renal, spinal and mental symptoms. It took about 5 of the powders to produce the desired effect on the bowels. Pulvis purgans (co. jalap. powder) had previously been given in a 5ii dose without cathartic effect.

So mildly did the cathartic act in this case that I repeated its use twice with the most satisfactory results and from my experience on this and other occasions I am convinced that the dread entertained of it is misplaced and that it is not only a most certain and reliable therapeutic agent, but also a mild and unirritating one used in the manner above mentioned. It deserves to come into more general use and not be reserved as a sort of *dernier resort*. Bromide of potassium and morphia, and friction along the spine and limbs with chloroform and aconite liniment, constituted the chief part of the remaining treatment, and under these he was enabled on the 9th day to pass voluntarily about four pints of urine and to have a natural voluntary evacuation. His sight again appeared normal and he was able for short periods to lie on his back. His neck cramp slowly subsided, but for weeks he suffered from debility, and from an affection of the heart, which appeared to be organic, although it has entirely disappeared. I should have stated that he had an erratic fever and some bronchial catarrh.

I have had the good fortune not to lose any of my patients so far, although one old gentleman died within 48 hours after discharging me and calling in a homœopathic physician. He was over seventy and suffered from a severe broncho-pneumonia, and was a most unpromising patient, having such extreme

weakness of the heart that he fainted repeatedly from moving or sitting up in bed. I had kept him alive, as I believe, for several days, solely by the use of stimulants, strophanthus and carbonate of ammonia, and I attributed the fatal result (which I do not deny might possibly have occurred even if no change had been made) to the abandonment of this line of treatment consequent upon the change of attendants.

But any one who has treated aged and decrepit persons in this disease knows what watchful care and nursing they require and that the flame of life seems often to be flickering in its socket in these old people for hours or days at a time. The worst feature about them is that they become apathetic and want to lie undisturbed and die. They lose all desire for life; we must force food and medicine upon them if we would ward off the fatal and impending event. Two old ladies nearly ninety years of age have recovered under my hands from a condition as extreme as that of the old man. They were delirious, nearly pulseless, passed urine and fæces involuntarily, and one had bed-sores, and it was only by the persistent efforts of friends in carrying out my directions that they were tided over days and nights when we thought every moment would be their last.

Depressing agents of any sort are evidently rarely admissable in a disease presenting such a tendency to debility as this and I have ventured in only a very small number to resort to small doses of ipecacuanha and tartar emetic; aconite and veratrum viride I have never used. The carbonate and muriate of ammonia are the most generally applicable

remedies and are rarely amiss, the former being preferable in very old or debilitated subjects, and in cases characterized by great weakness of the heart. For ordinary cases the muriate of ammonia is the best and may be used from the beginning. It should be given in full doses, as in the following formula:

R.—Ammon. Mur.,  
 Extr. Glycyrrhizæ . aa ʒii.  
 Morphiæ Sulph., . gr. i.  
 Vel. Codeinæ Sulph. . gr. iv.  
 Syrupi . . .  
 Aquæ . . aa ʒii.—M.

S. Two to four teaspoonfuls every three or four hours.

The pains are often severe enough to require special treatment. Sometimes it becomes necessary to resort to the subcutaneous injection of morphia, but ordinarily we secure relief by some of the new antipyretic-analgesics, antipyrine, acetanilid, phenacetine, which at the same time benefit the patient by relieving his fever, setting up a perspiration and promoting sleep. These can be used efficiently in small doses, much smaller than were formerly thought sufficient, and the depressing effect which some fear is imaginary except in rare instances. Moreover, the patient is protected by the ammonia which he is taking and by stimulants which may be given with the antipyretic. Some go further and administer quinine with the latter as advised by DaCosta, as,

R.—Quiniæ Sulph., gr. i-ii.  
 Antipyrine vel. Phenacetine, gr. iii-v.

To be given every two to four hours, and alternated with ammonia mixture.

I have experienced the benefits of another agent of this class in my own person so markedly that I must include

it in my mention; that is exalgine. In the dose of four grains every four hours it gave great relief and comfort and seemed to hasten greatly the resolution of the very severe head catarrh from which I chiefly suffered. Using it at first by accident, I learned by experience to prize it as the best of these remedies for all painful neuralgic affections.

Inhalations of hot water and spraying the throat and nose with Seiler's and other antiseptic solutions are useful measures and drinking hot tea is very grateful to an inflamed throat, besides promoting perspiration. Local applications are helpful, as hot turpentine stupes to the chest for a few minutes twice a day, or mustard; chloroform and aconite liniment is better for the neuralgic and spinal pains and also for rubbing the limbs. The constipation, furred tongue and foul breath call for a purgative, or Rochelle salts or two or three compound cathartic pills. Nausea, vomiting, epigastric pain and tenderness and diarrhœa or straining call for such remedies as morphia, bismuth, hydrocyanic acid, chalk mixture, small doses of calomel, etc. For sleeplessness, bromide of potassium is the best remedy.

Absolute rest is of the first importance and we should insist on the patient going to bed for two or three days at least. The good effect of this is often at once apparent in the improvement in the patient's pulse and the promotion of his comfort. Liquid and nutritious food should be given at frequent intervals and in many cases stimulants will be imperatively required.

During convalescence tonics are to be given, especially strychnia, quinine and iron—the elixir of the pyrophosphate



meeting the indication well. I think well of the syrup of hypophosphites (especially that preparation known in Baltimore as "Ruber") in the dose of 3i ii, three to six times a day. Cod liver oil and preparations of malt help the recovery. By these measures I have invariably succeeded in giving my patients relief and conducting the disease to a favorable termination.

### ALTITUDE.

BY ALUARD WHITE, M. D.,  
OF EL PASO, TEXAS.

If one may judge from the class of pulmonary invalids, who with the consent, and by the advice of their physicians in the East, come to the mountain region in search of health, there still exists a great lack of appreciation of the conditions to which the altitude treatment is adapted; and more marked still is the evidence of a lack of proper appreciation of those conditions which constitute a positive contra-indication. So far as altitude is concerned, patients with pulmonary disease may be divided into three classes—those who derive benefit, those upon whom change of residence has no appreciable effect, and those who are made distinctly worse, whose death is hastened, by the changed conditions. In illustration, I shall cite briefly the history of two cases that were under observation last winter. The first belongs to the category of those who derive benefit from altitude—is, in fact, a convincing argument in its favor. The second with equal force illustrates the evil consequences that arise from subjecting unfit subjects to its influences.

Of course, but for the labor of compilation, it would be easy to multiply indefinitely examples of both the foregoing classes of invalids, and it would be equally easy to cite cases where altitude has no appreciable effect, but for the purpose I have in view it is not necessary.

Case 1.—C. G., male, age 23 years, from Kansas City, Mo., by occupation a bookkeeper. First seen January 3, 1893. Complained of cough, expectoration, night sweats, loss of appetite, etc. Patient's family history is good, no instance of tuberculosis in his immediate family. Gave history of an attack of *la grippe* eight months previously, with partial recovery therefrom, and return to work; subsequently had two or three profuse attacks of "spitting of blood," which he says came from his throat, and by which he was so much debilitated as to determine him to come here with the hope of benefit. On January 3rd, at 12 M., patient's condition was as follows: pulse 120, respiration, 30, temperature 103.2-5, flushed cheeks, an anxious expression of countenance, frequent cough, with mucopurulent expectoration.

Examination of chest disclosed positive evidence of infiltration of upper lobe of left lung, with softening. Microscopic examination of sputum shows presence of bacilli in large numbers. Patient was ordered creasote t. i. d., a generous, liquid diet, camphoric acid for night sweats, and an antiseptic inhalant, composed of creasote, eucalyptol, and chloroform, with the result that improvement was manifest from the start, the range of temperature diminished, night sweats ceased, cough became less frequent, expectoration less in quantity and improved in character, appetite improved,

On May 3rd, four months after the first observation, patient reports that he has gained 20 lbs. in weight, has ceased to have night sweats, that temperature never exceeds 100, cough and expectoration so much improved that they no longer constitute serious disturbing symptoms; in fact, says he feel well and wants to return to Kansas City. Bacilli are still present in sputum, though in less numbers.

CASE 2.—J. K., male, age 54 years, resident of St. Louis Mo., occupation foundryman, for past five years has suffered from chronic bronchitis, with cough and shortness of breath; the two last preceding winters he has spent in the south, and obtained great relief therefrom. He left St. Louis four weeks ago, *i. e.*, on Oct. 10th, in his usual state of health, intending to spend the winter in Southern California. At the suggestion of some friend he concluded to stop over for a few days at Las Vegas, N. M., which is situated at an elevation of 7000 *feet above the sea*. He commenced to have a feeling of increased discomfort, dyspnoea, hoarseness, and exaggeration of cough several hours before reaching Las Vegas; a few hours after his arrival he became completely aphoric, cough was continuous, dyspnoea intense and had profuse bronchorrhoea. Was told by persons there that the symptoms from which he was suffering were not unusual in persons with weak lungs upon first coming into that high altitude, and that he would get better in a few days. He remained there three weeks, getting worse all the time, and was then advised by his physician to come to El Paso, as the elevation there was too great for him. He reached here about Nov. 5th, when

his condition was as follows: Pulse weak, 130 per minute, respirations 55 per minute, temperature 100, extremities œdematous, dyspnoea extreme, cyanosis marked, voice completely lost, cough persistent, with profuse bronchorrhoea, tongue large, flabby and heavily coated, bowels constipated, secretion of urine scant. In a word, there was intense passive venous congestion of the digestive and respiratory tracts: *the logical result of the effect of altitude upon an already weakened and dilated right heart*. The subsequent history of this case is briefly told; his manifold symptoms became rapidly exaggerated in intensity and he died in three days after his arrival here, completely waterlogged—drowned if you please—in the fluids of his own body.

His death certificate, which by the laws of the State has to be pasted on the coffin before the remains can be shipped away for burial elsewhere, should have read:

Causes of death: 1st, Predisposing chronic bronchitis with weak right heart. 2nd, Exciting cause, *altitude*. 3rd, Immediate cause, asphyxia.

The lesson taught by these two cases is so plain that it hardly needs dilating upon. We have but to note the salient features of case I in order to have a safe guide for future following in the matter of what class of patients should be advised to seek a higher altitude for their betterment. In a word, to note that though the patient was suffering from a well-marked and unmistakable case of tuberculosis, that it was of comparatively recent origin, that the extent of lung tissue involved did not comprise more than half of the left upper lobe, that the stage of softening had just commenced,

that the amount of lung involved was not sufficient to cause serious embarrassment of the respiratory function, that it did not constitute a serious obstacle to the pulmonic circulation as would have been evidenced had it existed by clubbed fingers, a dilated right heart, breathlessness upon slight exertion, etc. And as the result demonstrates, the pernicious influences at work had not wrought sufficient injury to the functioning capacity of the digestive and circulatory organs, or to the recuperative powers of the system, to prevent arrest of the disordered processes, and a gradual restoration of health, conditions thereto being favorable. And in any case this last is the sole consideration to be determined in deciding as to the expediency of sending patients suffering with tuberculosis to a higher altitude. On the other hand, case II presents a consensus of symptoms that constitute a positive *contra*-indication, *i. e.*, a weak, dilated, right heart; which in the instance before us was the result of a long existing chronic bronchitis, presenting, as it became more aggravated, an ever-increasing obstacle to the right heart in the proper performance of its function.

It matters not what the character of the lung lesion, if it so far trenches upon the carrying capacity of the vessels of the pulmonary circulation as to require increased effort upon the part of the right heart to propel a given quantity of blood in a stated time, there you have the obstacle, there is your *contra*-indication. An obstacle that increases with an ever-increasing ratio as the subject passes from the barometric conditions that exist at the sea level to those that prevail in higher altitudes.

In conclusion let me say that I have dwelt upon but one of the many well recognized *contra*-indications not because I wish to detract from the value of the others, but because my observation has taught me that a proper observance of this one will save many invalids the tedium and expense of a long and useless journey from which they can by no possibility derive benefit; on the contrary, the changed conditions will prove positively deleterious and but serve to hasten their progress to the grave.

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The Interior Department, in asking for its several annual appropriations from Congress for the expense of the Department, estimated that it would require \$2,000,000 for the payment of medical examiners for the Pension Department.

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In the Death of Dr. Charcot, the profession of France has lost one of its most active and distinguished members. He was a man of brilliant genius and whatever subject he touched in medicine was illuminated by his investigations. Few men of his generation have reached the position he attained and few will occupy a higher position in the history of medical science.

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Doctor—"Well, Dennis, did you take the pills I sent you?"

Dennis—"Indade, doctor, an' I did not; ye wrote on the box 'One pill three times a day,' an' I've been waitin' till I see you to ask you how a man was to take a little bit av a pill loike that three times in wan day?"—*Harper's Weekly*.



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BALTIMORE, OCTOBER 14, 1893.

Editorial.

CHLOROFORM IN LABOR.

There can be no doubt of the fact that the indiscriminate and routine practice of using chloroform in every stage and case of labor should be discouraged upon moral as well as upon scientific grounds.

Labor is a physiological function, and in the vast majority of cases it should terminate without interference upon the part of a meddlesome accoucheur.

The indiscriminate use of chloroform is an assumption that the conditions which attend labor are abnormal and, therefore, demand an interference.

In the *Virginia Medical Monthly*, October 1, 1893, Dr. John N. Upshur, of Richmond, Va., in a conservative and judicious paper discusses this subject with reference to the indications for the therapeutic use of chloroform in labor. Dr. Upshur claims that a loyal devotion to true obstetric science demands that

chloroform in labor should be exhibited just as other therapeutic agents in the treatment of other maladies.

He holds that labor only becomes pathological when conditions arise to convert a eutocia into dystocia or when the physical conformation of the pelvis is such as to prevent the accomplishment of natural delivery by mechanical obstruction from errors in pelvic conformation, malposition of the child or monstrosity. When a labor has become pathological in character an anæsthetic is demanded as in any surgical procedure as a safeguard to life.

The use of chloroform is in a sense a measure of compromise. It is an admission that the patient must accept the lesser of two dangers—the trials, pains and dangers of labor, or the injurious influence of the anæsthetic.

In normal labor the risk to life is trivial, both from the act of parturition and from the anæsthetic, but there is a debit and credit to both accounts. For the immunity from suffering the woman assumes a hazard which can not be estimated until the ordeal of labor has terminated.

Dr. Upshur discusses the dangers of chloroform under the following heads: Danger from *reflex* irritability, interference with voluntary assistance and the expelling forces, predisposition to uterine hæmorrhage, diminution of retractility and consequent tendency to subinvolution and septic infection.

The interference with oxidation of the blood endangers the life of the child and "its use in natural labor increases the percentage of still-births."

With these conditions and elements of risk in view, chloroform should be administered with discretion and prudence

in labor. Dr. Upshur's conclusions are worthy of consideration:

"In the light of the foregoing facts, I most earnestly avow my belief that we, as physicians, should place chloroform upon the same platform as other drugs; not be influenced by our sympathies, aroused by the pleadings of patients, or the fashionable routine practice of the day; but initiate and sustain a much needed reform in our obstetric work, chloroform being administered, as other agents, when the indications in the case imperatively demand it, not unless. He is a bold man who, invading the domain of nature, interferes with her physiological processes and places the wife and mother in a position of increased peril, and perchance the shadow of a fatal issue, or, at least, a life of invalidism and suffering, where before the home was irradiated with the effulgent rays of the sunlight of true and unalloyed happiness."

#### MEDICINE AND THE WORLD'S FAIR.

It can not be claimed with any degree of justice that the medical exhibit at the World's Fair was up to the standard of the various other exhibits in the arts and sciences. The reasons for this are quite apparent. With the exception of an exhibition of plans for hospital construction and management, of surgical instruments and appliances, and of pharmaceutical preparations—the paraphernalia and armamentarium of the medical practitioner—there is no way of illustrating the immense progress which medicine and surgery have made within recent years. In the departments of bacteriology and of preventive medicine

an exhibit was presented, but it scarcely represented the value of the work which has been done in these lines of investigation.

An exhibition of a cœliotomy for a hysterectomy or for a ruptured tubal pregnancy, or the opening of the cranium for a cerebral tumor, was, in the nature of things, an impossibility, and an exhibit which the general public was supposed to have no interest in.

The thousands of intelligent physicians who visited the Fair may have experienced a sense of disappointment in viewing the medical side of the greatest show yet known to man in contrast with the marvelous display in the liberal arts and mechanical sciences. As an objective lesson we doubt not that the observing physician found ample material for study and reflection.

He was no doubt reminded of the fact that the science of medicine is a part and parcel of that great system of human effort which found expression in works of art and science which have contributed so much for the service of man by the subjugation of the material forces around him and the creation of ideals and influences which improve the moral and intellectual condition of the human race. Such an exhibition of man's ambition, energy and intellectual achievements cannot fail to exert a beneficial influence over the profession of medicine, which possesses to an eminent degree all these essentials to progress and development.

#### THE RECENT PAN-AMERICAN CONGRESS.

The medical journals of this country have been profuse in their praises of the recent Pan-American Congress



We do not doubt that this praise is well merited. The Congress may be said with perfect justice to have been a success in more respects than one. Scientifically considered it did not reach above the standard of the late International Congress, but looked at from other points of view the work accomplished by the Congress was quite worthy of the occasion which it inaugurated—an era of good feeling and of acquaintanceship among the profession of the Americas. This object in itself was a sufficient justification for such an assemblage of medical men. Professional gatherings can be made profitable in many ways and we can not think that too much consideration is ever given to the social side of such meetings. Not only are agreeable and pleasant acquaintances made upon such occasions, but the mere contact of mind with mind—the seeing and knowing—is a stimulus to work and motive, to cordial and congenial relations for the future. The *esprit de corps* of the profession is moved up to a higher platform by such influences as these meetings beget.

The organization of the profession in the United States has grown with remarkable rapidity within the past twenty years.

He must be a narrow pessimist who sees no progress in this day in higher ideals and methods of work.

The rapid growth of the profession as well as the marvelous restlessness and enterprise which characterize this era of investigation and of advance make it necessary that professional organization should direct the methods of work and lines of thought along which this army of men is moving. Otherwise conserva-

tism, which should always hold full sway, is in danger of being crowded to the rear by that restless radicalism which is always leading the advance guard in original work.

The coming together of representative men from Southern, Central and Northern America is an event of no mean importance or significance. It means good for the medical profession and for the nationalities thus represented.

#### HARD TIMES FOR PHYSICIANS.

The stringency of the times, such as this country is now going through, bears on all classes of citizens. The merchant, manufacturer and the farmer fare no worse than the practitioner of medicine who is a bread-winner in the strict sense of this term. The physician suffers in a two-fold manner. People learn to economize in medical service as in other necessities of life, and many who in times of greater business activity are ready to call in the physician now do without his services whenever it is possible. The amount of medical service is, therefore, greatly reduced and men of large practice are heard now to complain of scarcity of work. This condition of affairs applies equally to the city and country practitioner. Men who are engaged in special work experience the same results. The ordinary chronic ailments which give much work to the specialist go neglected oftentimes from force of circumstances as they now prevail.

In point of collections for services rendered the same rule applies. The physician's bill is secondary to other calls and usually is the last to receive atten-



tion when a reasonable excuse exists in the minds of the average patient for its neglect.

The unusual depression which has fallen upon the agricultural classes has borne heavily upon the country practitioner, but this solace remains to this class of our profession: his expenses for rent, food, fuel and clothing can be minimized whilst with his brother practitioner of the city, the grocer, baker and candlestick-maker are ever at his door in quest of overdue bills.

Amidst such times there is need for patience and reflection. The true physician does not count results in material gains, but is ever found faithful to duty, courageous and heroic in times of danger, resolute and strong in times of emergency and ever trustworthy in the duties of citizenship.

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### Reviews, Books and Pamphlets

*Electro-Therapeutics in Neurasthenia*; by W. F. ROBINSON, M. D. 1893: Geo. S. Davis, Detroit, Michigan. Paper, 25cts. Physicians' Leisure Library Series.

*Sterility in the Woman, and its Treatment*; by Dr. DE SINETY. Translated by E. P. Hurd, M. D., 1893. George S. Davis, Detroit, Michigan. Physicians' Leisure Library Series.

*The Bacterial Poisons*; by Dr. N. GAMALEIA. Translated by E. P. Hurd, M. D., 1893. George S. Davis. Paper, 25cts. Detroit, Michigan. Physicians' Leisure Library Series.

*A Manual of Diseases of the Ear*; by GEORGE P. FIELD, M. R. C. S., Au-

ral Surgeon and Lecturer on Aural Surgery, St. Mary's Hospital Medical School, London. In one octavo volume of 391 pages, with 73 engravings and 21 colored plates. Cloth, \$3.75. Philadelphia: Lea Brothers & Company, 1893.

The frequency of aural affections, the apparent difficulties of treatment and the severity of the results of neglect, all combine to render a plain and authoritative volume an acquisition of great value to the student and general practitioner. The work possesses even greater importance to the specialist, since it embodies the experience of a gentleman occupying the chair of aural surgery in the first London school offering instruction on its subject. The demand for four editions testifies to its merit.

We take pleasure in recommending this very attractive volume to the consideration of our readers.

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### Medical Progress.

#### APPENDICITIS.

Dr. George H. Sanborn, of Henniker, read a lengthy paper before the New Hampshire Medical Society (*Boston Medical and Surgical Journal*) and concluded as follows:

1. That in all cases the physician is concerned only in the early recognition of the disease, the subsequent treatment to be left to the surgeon.

2. That the catarrhal or mild form of appendicitis may be considered the only medical form of the disease; and delay in operating may be encouraged to a reasonable extent.

3. All cases of appendicitis which, at

the end of thirty-six hours from the beginning of the attack, show signs of increasing disease, should be operated on.

4. That the majority of so-called recoveries, treated medically, are not recoveries in the full sense of the word, but simply a respite which enables one to settle worldly affairs, and take out a life-insurance policy, in anticipation of a fatal termination.

The early surgical treatment of appendicitis enables us to avoid in every case uncertain results of a spontaneous cure, the danger of recurrent attacks and the often fatal general peritonitis in apparently mild cases.

#### EXCISION OF THE OSSICLES OF THE EAR.

In discussing this subject and illustrating it by means of case-records from his own practice, Dr. Milligan (*British Medical Journal*, September 9th) says:

In the performance of the operation, a strong and steady light is essential. I have in all my operations made use of the light from a lime-light apparatus reflected by means of a forehead mirror. The patient should be placed under the influence of an anæsthetic, and the head allowed to rest upon a firm and flat sand pillow. The meatus and the skin of the external ear should be carefully cleansed with some antiseptic lotion, and then filled with a 20 per cent. solution of cocaine for a few minutes. By doing so, the vascularity of the tissues is considerably reduced—a by no means unimportant advantage. A circular incision round the remaining portion of the membrane is now to be made with a probe-pointed straight knife. The tendon of the tensor tym-

pani, if still intact, should now be divided close to its insertion into the long process of the malleus. The superior ligament of the malleus is then divided and the ligaments of the malleo-incudal joints severed as completely as is possible. A fine pair of forceps or the loop of a delicate snare should now be made to grasp the handle of the malleus, and gentle traction exerted until the ossicle comes away. If on examination the incus is now found diseased, it should be drawn down into the field by means of a fine hook, for example, that of Kretschmann, Ludwig, or Ferrer, and the ligaments of the incudo-stapedial joint divided by a specially-devised angular knife. If, however, the incus is found to be diseased prior to the performance of any operation, it is advisable, after having divided the membrane, to cut the ligaments of the incudo-stapedial joint first of all, and then to remove incus and malleus together.

During the performance of the operation, any oozing of blood should be rapidly mopped up with cotton-armed probes (the operator should have a number lying ready at his side). The ear should then be irrigated with a warm solution of boracic acid, the parts carefully dried, and a small quantity of some antiseptic powder insufflated at once. In those cases complicated by the presence of parietal caries, small curettes or spoons should be used to scrape away as much of the disease as is possible. The chorda tympani nerve, if not already gone, is in imminent danger of being wounded, or even completely divided. Loss of taste over the corresponding side of the tongue results, but as a rule is recovered from. The facial nerve

may be injured, and in several recorded cases has been so, but permanent paresis or paralysis is unusual. The patient should be kept quiet for a few days after the operation, and light and non-stimulating diet given.

In the following 15 cases the operation was carried out as described, and with the following results: Cured, 11; improved, 2; still under treatment, 2.

The condition of the ossicula was as follows: Malleus healthy, incus carious in 5 cases; malleus carious, incus healthy in 6 cases; malleus carious, incus carious in 4 cases. Among the 15 cases operated upon a new membrana tympani has formed in 10. In 2 cases described as improved, and in one of the cases described as cured, there is no sign of regeneration of the membrane. In the two cases still under treatment a new membrane is showing signs of forming. Among 13 cases operated upon (the 2 cases at present still under treatment are not included) hearing was found more or less improved in 8, remained as before in 3, and was rendered distinctly worse in 2.

At the same time it must be borne in mind that operative interference is directed in the first instance to check the suppurative process, and not to restore the hearing power.

In favor of this operation it may be said that its risks are slight, but against it must certainly be pointed out that its performance is difficult. The lumen of the meatus allows but scanty space for the free play of instruments, and the obscuring of the field of operation from the oozing of blood is a source of constant annoyance to the operator. At the same time, in those cases of "attic

disease" where ossicular caries can be demonstrated, this form of procedure seems to me to answer the requirements of the case.

Should this operation fail to arrest suppuration, it is always possible to resort at a later date to opening the antrum and clearing out the contents of the middle ear. Recovery is decidedly more rapid after the excision operation than after antrectomy, and the pain of the subsequent dressings is decidedly less. At the same time, the cases in which such an operation is useful are not numerous.

The following conclusions are, I think, justifiable:

1. That when in those cases of chronic suppurative middle ear disease accompanied by perforation of Shrapnell's membrane, and the presence of parietal or ossicular caries, the most careful local treatment has been carried out, and has failed to effect a cure, the operation of excision of the membrana tympani and of the ossicula auditus should be performed.

2. That, as a rule, purulent inflammation ceases, or, if not, is at least greatly reduced in the intensity, after the performance of the operation.

3. That such symptoms as vertigo, tinnitus, etc., are either cured or greatly relieved.

4. That recurring attacks of earache are checked.

5. That the hearing power is either improved or remains as before.

6. That in a few cases the hearing is rendered rather worse.

7. That in cases of chronic attic disease, with normal atrium, the only perforation being the membrana flaccida



Shrapnelli, the performance of this (or some similar) operation is probably the only means of cure.

PULMONARY TUBERCULOSIS WITH  
ESPECIAL REFERENCE TO ITS  
PROPHYLAXIS, HYGIENIC  
AND CLIMATIC  
TREATMENT.

Dr. Edward O. Otis, of Boston, in a paper with the above title (*Brit. Med. & Surg. Jour.*) says:

There are certain general facts which I hold as true, regarding pulmonary tuberculosis; and it may be as well for me to present them axiomatically at the outset:

1. Pulmonary tuberculosis is, in the greater number if not all cases, a disease of in-door life and impure air.

2. The first downward step towards pulmonary tuberculosis is impaired general nutrition.

3. Improper breathing and insufficient lung ventilation may finally result in pulmonary tuberculosis.

4. Pulmonary tuberculosis is inheritable in the common acceptation of the term.

5. Pulmonary tuberculosis can be cured or arrested in not an inconsiderable number of cases.

6. There is no specific for the disease.

7. The successful treatment is hygienic and climatic; and under hygienic I include lung gymnastics.

8. Pulmonary tuberculosis is capable of being cured or arrested in any and all climates, but more readily and surely in some than in others.

Let me now enumerate a set of inter-ratories for the physician to put to himself in his prophylactic endeavors to avert this disease:

1. Nutrition: Is proper food and of

sufficient quantity taken? and is digestion and assimilation good?

2. Respiration: Is the breathing full and free? and is there good action of the respiratory muscles?

3. Air: Is pure air and of sufficient quantity supplied? This is of especial importance in sedentary in-door occupations.

4. Physical exercise: Is sufficient and proper physical exercise taken to ensure good respiration and circulation and proper elimination of waste products?

5. Situation of dwelling: As to character of soil (damp or dry) and drainage.

6. Light and sunshine—with especial reference to in-door life: Do working-room, sitting-room and bed-room have sufficient light and sunshine?

7. Clothing and bathing: Is the clothing sufficient and of proper texture? and is bathing sufficiently frequent, not only for cleanliness, but to give tone and vigor to the peripheral blood-vessels?

8. Mental condition: Do worry and a depressed mental state exist?

POSTERIOR URETHRITIS.

In a paper read by Dr. Bransford Lewis, editor of the *Fortnightly*, the following conclusions are presented:

1. The causes usually given for the prolongation of clap (presence or absence of gonococci, stricture of large calibre, the use of particular drugs in treatment, etc.) do not satisfactorily explain them, nor do they furnish reliable means for prognosticating the outcome of a case.

2. A single widely prevalent cause for such prolongation of gonorrhœa has, as yet, not proved its right to recognition as such.

3. Posterior urethritis, by reason of its

anatomical seclusion and inaccessibility to ordinarily-prescribed treatment, if frequent, offers the best explanation for such prolongation or repeated recurrence.

4. Scrutinizing clinical investigation shows posterior urethritis to be present in the great majority of cases of prolonged or severe gonorrhœa.

5. Direct, topical treatment to the posterior urethra is, therefore, necessary in the great majority of cases.

6. The causes usually given for producing posterior urethritis are not commonly found to be real factors in the clinic.

7. The mode of onset usually described does not coincide with that discerned in clinical observations.

8. These two latter observations confirm the probability that the posterior urethral infection is accomplished through the lymphatics, and explain the frequency of such infection.

9. Posterior urethritis is not a complication, but a natural phenomenon of gonorrhœa.

#### GOOD CAUSE FOR SUICIDE.

The *Montreal Med. Jour.* is responsible for the following:

William Harmon, a resident of Titusville, Pa., committed suicide a few days ago from a melancholy conviction that he was his own grandfather. Here is a singular letter that he left: "I married a widow who had a grown-up daughter. My father visited our house very often, fell in love with my step-daughter and married her. So my father became my son-in-law and my step-daughter my mother, because she was my father's wife. Some time afterwards my wife had a son;

he was my father's brother-in-law and my uncle, for he was the brother of my step mother. My father's wife, *i. e.*, my step-daughter, had also a son; he was, of course, my brother, and in the meantime my grandchild, for he was the son of my daughter. My wife was my grandmother, because she was my mother's mother. I was my wife's husband and grandchild at the same time. And as the husband of a person's grandmother is his grandfather, I was my own grandfather."

#### SOME RESULTS IN THE TREATMENT OF EPILEPSY.

Dr. David Inglis, in *Therapeutic Gazette*, says:

I believe that the routine use of bromides does serious harm. That it is a serious mistake to go doggedly on with bromides in any case in which the attacks of grand mal, but more especially of petit mal, persist or increase in frequency while the patient is taking bromides.

I believe that bromides should be given in full doses to begin with, so that if they are to prove of benefit in a given case the good effect will be promptly shown. The dose should then be diminished, and always carefully watched. Failure of memory, mental torpor, change of character, are worse things than occasional nervous explosion, and, when the toxic effects of the bromides first appear, the use of the drug ought to be stopped at once.

I believe that we have in antifebrin and its analogues a group of remedies which form efficient substitutes for the bromides. They can be given for long periods with marked benefit, and their use is without any deleterious effect upon the mental state. This alone gives them

an immense advantage over the bromides. One precaution, however, must be observed. The drugs need not be given in large doses, but there are persons on whose circulatory apparatus even moderate doses exercise a depressing effect. Such cases are not fit for the antifebrin treatment.

That the antifebrin group has a profound power over the cerebro-spinal axis is demonstrated by the effect which we so well know upon reducing temperature. My experience with this class of remedies in diabetes has corroborated my reliance upon them, and certainly the experience upon which this paper is based goes far to prove that prompt and thoroughly satisfactory effects in controlling the epileptic explosion can be expected.

#### HORSE-HAIR IN MINOR SURGERY.

Dr. C. O. Thomson, in an article with the above title in the *Brit. Med. & Surg. Jour.*, Oct. 5th, 1893, sums up the following advantages of horse-hair:

1. Easily obtained and inexpensive.
2. Soft, pliable, elastic and holds a knot well.
3. Aseptic, non-absorbent and non-irritating.
4. Can be used with a very small needle, and makes no shoulder at the eye.
5. More easily removed than any other suture, without pain or injury to the tissues.
6. Can be used for drainage.

#### THE HEIGHT OF MAN.

A French statistician has been studying the average heights of men at different periods of the world's history, and has reached some alarming conclusions.

The recorded facts extend over nearly three centuries. It is found that in 1610 the average height of men in Europe was nearly 6 feet 6 inches. In 1790 it was 5 feet 6 inches. In 1820 it was 5 feet 5 inches and a fraction. At the present time it is 5 feet 3 $\frac{3}{4}$  inches. It is easy to deduct from these figures a rate of regular and gradual decline in human stature, and then apply this, working backward and forward, to the past and to the future.

By this calculation it is determined that the stature of the first man attained the surprising average of 16 feet 9 inches. The race had already deteriorated in the days of Og, and Goliath was quite a degenerate offspring of the giants.

Coming down to later time, we find that at the beginning of our era the average height of a man was 9 feet, and in the time of Charlemagne it was 8 feet 8 inches.

But the most astonishing result of this man's study comes from the application of the same law of diminution. It is conclusively shown that in 4000 A. D. the height of the average man will be but 15 inches, and in a few thousand years more the end of the world will come, for men will get so short that there will be nothing left of them.—*Buffalo Express*.

#### TYPHOID FEVER AND ITS SUCCESSFUL TREATMENT.

In a paper with the above title in *New Remedies*, Dr. J. Hobert Egbert says: Phenocoll is an ideal remedy in typhoid fever—being a safe and certain antipyretic and a powerful antiseptic. It meets the two desiderata in this dis-



ease, to wit, certain antiseptis and safe antipyresis, without disturbing the normal physiological action of the tissues, but, on the contrary, assists in restoring the normal bodily functions and promotes elimination of the poisonous products of perverted tissue change.

If the diarrhœa is very troublesome the following powder may be employed:

R.—Salol . . . 5ss.  
Bismuth. Subnitrat. 5i.  
Pulv. Doveri . . grs. xx.

M.—In chart. No. v divide.

Sig.—One powder every two, three or four hours.

The value of cold bathing or douching in typhoid fever is now well established. In hospital practice the Brand system gives the best results, but with private cases it is frequently impracticable. However, the body should be well bathed with cold water two or three times a day until the fever subsides. Cold bathing not only reduces the temperature, but also vitalizes nerve-centres and promotes rest and comfort. Where practicable—especially in cases of high temperature and much delirium—the tub can be employed. The addition of a small amount of lysol, or other non-poisonous disinfecting fluid, to the bath may prove advantageous.

### Recommendations of Therapeutic Agents.

Dr. F. C. Ford, of Nacodoches, Texas, Medical Director of Texas Volunteer Guard, State Troops, says that antipyrin is a prompt styptic, and can be relied

upon to arrest hæmorrhage when other remedies fail. He made the discovery recently. Being called upon to remove a small vascular tumor in the mouth, an apparently insignificant matter, he had difficulty which he did not anticipate in stopping the blood. He touched it first with a point of nitrate of silver and it had no effect; he then applied antipyrin in powder, with the result, as stated, of immediately arresting the flow.

The Doctor does not know what prompted him to do it, as he had never heard it recommended, nor was it suggested by the knowledge that antipyrin possesses any astringent properties; it is just one of those clinical facts which one cannot explain.

Dr. Ford further states that antipyrin can be relied upon in hæmorrhage after extraction of a tooth; he has not tried it in any other cases. Should experience confirm the Doctor's observation, and establish the fact that it was not a co-incidence but that the drug is really a hæmostatic, the discovery is of great practical value. All know the difficulty sometimes encountered in arresting apparently trifling hæmorrhage. In epistaxis, for instance, if it can obviate plugging it will be a most valuable acquisition to the surgeon's resources. The solution of perchloride of iron, the tincture of iron, and other preparations of the kind are often objectionable, while being, next to ligature, his principal resource. They leave an ugly sediment or deposit upon the wound, which has to be removed, and are sometimes contra-indicated by their irritant nature. Antipyrin will make a much more cleanly dressing, to say the least.

### Abstracts and Extracts.

*New Remedies* says: The application of guaiacol by painting the skin is, according to Robilliard, an efficient and convenient means of reducing the temperature of tuberculous patients. He has painted 0.5 to 2 grams guaiacol over 15 to 75 square inches of epidermal surface of tuberculous patient in whom fever ran high, and in every case the temperature fell one or more degrees. In his opinion these paintings act more quickly and more permanently than quinine sulphate. That the guaiacol is actually absorbed into the system is evident from the distinct guaiacol taste that the patients experience in the mouth, and also from the profuse perspiration. The quantity of urine at the same time increases, but no quaiacol can be detected therein.

Mr. Simeon Snell (Sheffield) related this case recently: A youth had been shot in the right eye by a pellet from an air gun, the wound of entrance being in the sclerotic, on the nasal side, above the insertion of the internal rectus. When seen two hours after the accident, some vitreous had escaped through a round hole about four millimetres in diameter in the sclerotic, and the interior of the eyeball was filled with blood. Next day the eye looked better. The vitreous cleared, and a hæmorrhage close to the optic papilla underwent absorption, disclosing a pigmented scar (wound of exit). Vision soon improved, and reached  $\frac{5}{6}$  and J. 1. The ophthalmoscope revealed a large atrophic area with pigment, especially at the edges, in the position of the wound in the sclera through which the pellet entered, and there was a corres-

ponding gap in perimetric chart. The place of exit was, as indicated, close to the disc. The date of accident was August 30th, 1892, and the sight remained good at the time of writing.—*Ophthalmic Review.*

Dr. Graham (*Amer. Jour. Med. Sciences*) points out that lumbago may arise from cold, strain, fatigue, or rheumatism. Its pathology is probably coagulation of the semi-fluid contractile muscular substance, and adhesion of muscular fibrils, so that motion gives rise to partial, irregular and painful contractions. Retention of waste products occurs, the worst of these being uric acid. Recent cases of muscular rheumatism are almost invariably cured by a few massages. The same result may be brought about by rest, warmth, electricity, or the use of such drugs as sodium salicylate, though not so rapidly. Graham claims for massage five different actions—namely, mechanical, thermal, electrical, nervous, and chemical, and suggests that when a case of apparent muscular rheumatism not only does not yield, but does not remain improved after a few massages, the probability is that the case is one of neuritis affecting the nerve fibres that supply the impaired muscles. This probability would be strengthened when the pain is uniform, affecting the same muscles on both sides, when it is worse at night, when at rest and warm in bed, and better when up and moving about; whereas muscular rheumatism is aggravated by motion and relieved by rest and warmth. Massage may thus be used as a means of diagnosis between muscular rheumatism and neuritis.

It is not surprising to those who have kept pace with the progress of antiseptics

to hear Sir Joseph Lister, after twenty years of investigation and experiment, declare his renewed allegiance to carbolic acid, as he did in a lecture January, 1893, at Kings College Hospital in London (*Annals of Surgery*, June, 1893). Carbolic acid is not only a more efficient surgical germicide than corrosive sublimate, but it is much more efficient in cleansing the skin. It has a powerful affinity for the epidermis, penetrating deeply into its substance, and it mingles with fatty materials in any proportion. Corrosive sublimate, on the other hand, cannot penetrate in the slightest degree into anything greasy; whence those who use it require elaborate precautions in the way of cleansing the skin. All of this is unnecessary with carbolic lotion. Sir Joseph does not even use soap and water, trusting entirely to the carbolic acid. There is a new product of phenol and boracic acid, disguising its odor, and greatly supplemented in its efficiency by its combination with boracic acid, which, although admittedly slower in its action, is nevertheless unsurpassed as a true germicide.—*The Medical Fortnightly*.

Children have a right to demand the completest cultivation of one of the most important organs given to them, namely, their voice. They cannot all be made good singers, but the voice of every individual child can be developed in the direction of being beautiful. I believe that nowhere on earth is the human voice more neglected than in America. The number of shrill, harsh-voiced girls that one comes in contact with daily is appalling. Too often not sufficient attention is given to the voice and the habit of loudness and carelessness of

speech is developed. The girl has been badly educated, and the boy as well, no matter what may be their accomplishments, unless they have learned that the secret of being understood lies more in the enunciation than loudness. There are more nerves being wounded and irreparably injured each day that passes by the beastly harshness and careless roughness of uncultivated voices than are being worn out by overwork or whipped out by alcohol.

It will be difficult for one who ever saw the beautiful Adelaide Neilson to forget her beauty, but no one who was fortunate enough to have heard the gentle, soothing notes of her lutelike voice will ever forget that. I think that the faithful one in dying, as he approaches the gates of heaven, may expect to hear notes reminding him of that voice. Is there anything that is more lasting and that more frequently comes back from the way-beyond, to the ear of a boy even though he has reached his second childhood, than the gentle echoes of a sweet-voiced mother? I recall a big, strong, rough-and-ready man to my mind, who, when dangerously ill, referred to his mother long since dead, and the strongest point he made in her favor was that she was a gentle woman and so kindly voiced as always to have had an influence over him in life, beyond that of anything on earth; and that the memory of her sweet voice came to him ever and often when tired, weary and worn, and gave him inspiration.—From an address by Dr. Love, *Journal of the American Medical Association*.

Oil of wintergreen for alopecia.—Dr. Hallopeau recommends the application of oil of wintergreen in the treatment of



alopecia. It does not cause irritation, so that its effect must be ascribed to a destructive influence upon the cause of the condition. The best results are obtained from a mixture containing equal parts of ether and oil of wintergreen.—*New Remedies*.

Should doctors charge dentists? is a question the medical journals are trying to decide. The boot might be wisely put on the other foot: Should dentists charge doctors? If a dentist is a graduate physician, the "courtesies of the profession" should certainly be accorded each other by both physician and dentist—at least so far as service and advice. Why not just the same if he is not an M. D.? However, it wouldn't be advisable, as has been seriously suggested, to attempt making the doctors' drugs off set the dentists' gold plates and gold fillings. Hardly!—*Med. News*.

"Is the doctor in?" asked a tramp at the door of an Arch street physician recently.

A few minutes later an oldish female came to the door.

"I jist wanted to see if the doctor would'n give me a pair of his old pants," said the tramp.

"I'm the doctor," replied the lady.

The tramp had several attacks of vertigo as he dropped down the steps.—*Philadelphia Record*.

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### Medical Items.

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Steps are being taken to establish a medical school in connection with Princeton College,

The annual session of the New York Medical Association is being held this week in New York City.

Dr. Christian Fenger has been appointed Professor of Surgery in the Chicago Medical College.

A skull has been discovered at Decelia which is believed to be the skull of Sophocles. Professor Virchow, who is an authority on skulls, has been called on to decide this interesting point.

Tramp.—Can you assist me along the road, mum?

Lady of the House.—Personally, I cannot, but I will unchain my dog, and I know he will be most pleased to do so.—*Tid-Bits*.

Workman.—I must go to the dentist and have my wisdom tooth pulled. Employer.—I won't allow it! You are stupid enough already. You had your wisdom tooth when I hired you, and you must keep it.—*Fliegende Blätter*.

The Harvard Medical School, which has adopted the four-year graded course, this year (says the *Boston Medical and Surgical Journal*) has an entering class of somewhat over ninety, a falling off of about twenty from the number last year.

It has been stated by Dr. Peter H. Bryce, of the Provincial Board of Health of Toronto, Canada, that 25 per cent. of all cases of diphtheria occur between the first and tenth year and that 55 per cent. of cases occurred among the school population of Ontario.

Bromide of strontium is recommended for the relief of vomiting. 15 grains

before meals relieves nausea, and 30 to 45 grains, administered in divided doses during the day, is said to be efficacious in relieving nausea and vomiting of pregnancy.

Dr. Davis says, *If pus is found in the urine* of a woman, the following treatment will be found very beneficial: the bladder should be douched with a solution of creoline of the strength of a drachm to a pint of warm water twice a day; and ten grains of salol or fifteen grains of boric acid should be given internally three times a day.—*Col. and Clin. Rec.*

Pennsylvania has 30 women dentists, Illinois 17, Kansas 13, New York 10, Ohio, Texas, California and Michigan 6, each, and Maryland, Kentucky, Georgia, Florida, Mississippi, Utah and South Dakota, one each. The District of Columbia has 3. A dental college for women is now in order.

*The College and Clinical Record* says: Prof. Hare is of the opinion that in *post-partum hæmorrhage* the salts of iron and Monsel's solution should not be employed as styptics, because the coagulation which they produce may extend well up into the uterine vessels, and when the clots are later on broken up by putrefaction the patient is placed in danger of septic poisoning.

At a meeting of the Baltimore Obstetrical and Gynæcological Society, held Oct. 10th, the following officers were elected for the ensuing year: President, Dr. T. A. Ashby; Vice-Presidents, Dr. J. Edwin Michael, Dr. G. Lane Taneyhill; Secretary, Dr. W. S. Gardner; Treasurer, Dr. R. T. Wilson. The Society meets on the second Tuesday of each

month from October until May. Its active membership is limited to 30. It now has some 25 members.

The Alumni of the University of Maryland who have not seen the recent improvements which have been made in the classical old University Buildings and grounds have a most pleasant and agreeable surprise in store for them. These improvements are of such a character as not only to add to the beauty of the institution, which for many years has been a landmark in our city, but greatly enlarge and improve the facilities for medical and scientific work, such as the University has recently inaugurated.

The death of Graily Hewitt removes from the profession of England one of its most noted workers in the field of obstetric medicine. For many years he was Professor of Obstetrics in the University College and Obstetric Physician to the University College Hospital, London. He was the author of a valuable and popular work on the Diseases of Women, which was revised and edited in this country by Dr. H. Marion Sims. Dr. Hewitt was 65 years old at the time of his death.

Surgeon-General Hammond, at the Pan-American Congress, read a paper in which he comes out in a flat-footed manner and says that asepticism is fetichism and that the days of antiseptics are numbered. That in ten years we will look upon the antiseptic method of to-day with ridicule and scorn; that the washing of wounds with corrosive sublimate and other germ-killers is a hoax and the soaking of instruments, etc., is utterly useless; that the only thing necessary is absolute cleanliness.—*Ex.*

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## Original Articles.

### OBSERVATIONS ON THE CLINICAL HISTORY AND TREATMENT OF PUERPERAL INFECTION.\*

BY THOMAS A. ASHBY, M. D.,  
Professor of Diseases of Women and Children in  
Baltimore Medical College, etc.

Labor seldom takes place, even under normal conditions, without more or less injury to the genital tract. The lesion may vary from a simple contusion to a most extensive laceration of the soft parts, limited either to the uterus or to the vulvar outlet, or extending throughout the entire genital canal. The parturient woman may be simply shaken up, to use a figurative expression, or she may be profoundly shocked by the ordeal of labor. In either condition she is receptive and less capable of resisting an infectious influence than she would be

under any other form of traumatism of similar degree. It is not, therefore, so much the extent of the traumatism she has experienced which predisposes her to infection as the condition of lowered vitality and of nerve irritability which are associated with the parturient act. A lesion of a very insignificant character may be sufficient under the conditions which surround the individual case to assume the most intense inflammatory and septic action. We may assume, then, that the symptoms observed after parturition do not necessarily bear direct relation to the extent or location of the lesion.

To clearly understand the clinical history of the lying-in woman, her condition must be viewed from three standpoints. *First*, symptoms referable to an aseptic fever. *Second*, symptoms dependent upon an extensive local inflammation in which infection has oc-



curred. *Third*, symptoms referable to pure infection where the local lesion is either not present, or if present is exceedingly insignificant and not directly accountable for the violence of the infectious influence. These three classes of cases may be observed after abortions, after miscarriages or after labor at full term.

The symptomatology of each class may be made out by careful investigation, where the observation is made in the outbreak and before an aseptic fever has had time to assume a septic characteristic. I am not prepared to admit as a result of my personal observations that infection is a necessary factor in all puerperal inflammations. I am prepared to admit, however, that it is most frequently present and that we must look upon the influence of the micro-organism as the main factor in the violent extension of inflammatory action and of systemic disturbance.

A lesion at the vulvar opening, within the vaginal canal or in the uterus, may be kept, theoretically speaking, as aseptic as an injury to a cutaneous surface or to bone or muscle, and provoke a train of symptoms, identical with an aseptic wound in these tissues—to wit, an accelerated pulse, elevation of temperature, dryness of the skin, pain and thirst. The constitutional symptom may be very mild and may run its course by rapid repair of the injured surface, and rapid subsidence of the general disturbance.

If one will take the pains to use the thermometer and to note with care the condition of the skin and pulse after labor, many cases of aseptic fever can be noted among lying-in women. These cases run their clinical histories

oftentimes with such apparent mildness as to escape observation, and it is only now and then that an alarming signal is giving.

So long as symptoms are noted with care and investigation shows no extensive local lesion, strict cleanliness, careful attention to the secretions and a regulated diet will meet the general indications of treatment.

It is not unusual to observe a septic fever after the primary operation for a torn perineum where an aseptic operation and treatment are rigidly enforced. In proportion as carelessness is in force or relaxation in a strict aseptic regime is witnessed, to that extent may infection retard the process of repair and lead to the extension of inflammatory and septic processes.

The symptoms of the patient and the condition of the wound will promptly indicate the septic influence. It is possible by judicious and prompt action to arrest a septic process before an extensive local or systemic disturbance has supervened, but let delay or hesitation ensue and we may have to face a conflagration which will demand our best efforts for its suppression.

I know of no conditions which so clearly prove the influence of an infectious principle as those which result from a simple traumatism in the genital tract and which can be traced to the careless and uncleanly management of the lying-in woman. I believe it is possible, in nearly every case, to trace the rise and spread of infection in the condition of lesion and to demonstrate the influence of the septic principle by prompt and intelligent methods of treatment. To accomplish this purpose, however, the lesion must be discovered promptly and

rigid methods of treatment must be instituted at once. So far as my experience goes I cannot see that these cases of infection in the lying-in woman, in the larger number of patients, differ in their essential characteristics from infection following injuries in other localities. The only differences which exist must be referred to mechanical conditions incident to the location and structure of the intra-pelvic organs and dependent upon the modifications of tissue resulting from pregnancy. If we exclude these factors we are essentially dealing with a traumatism as positive and real as one inflicted by blows or falls or from direct violence to the tissues by sharp-cutting or penetrating instruments. This view of the subject is by no means narrow and opens up a clearer understanding of the symptomatology and treatment of lesions induced by labor. To this view of this subject exceptions must be taken in the consideration of that class of cases in which infection can be traced to the debris of abortions and labor, in which no local lesions are observable.

In that class of cases the local conditions are apparent from the beginning and it is only the grossest carelessness which can lead to the retention of material within the uterus as food, for decomposition and infection.

Symptoms point to this condition in a very decided and positive way. Contractility and retractility are either modified or exaggerated, uterine pain is most commonly present, hæmorrhage may be either absent or excessive. Physical examination is usually alone sufficient to demonstrate the presence of retained material and its prompt removal is usually

all that is required to relieve symptoms and to arrest infection. In my recent experience, covering over a dozen cases of retained secundines following abortion and labor at full term, all but three cases, seen in consultation, hæmorrhage was the most alarming symptom. In two cases where the secundines were retained from one to two weeks after abortion I removed putrescent and loud-smelling masses, with immediate relief of symptoms and recovery of cases. These patients were exposed to the most filthy surroundings and were in the most unpromising condition prior to the removal of the retained secundines. I have never understood how they escaped the long period of infection, considering the condition of the decomposing masses I removed from them. Whatever be the nature of the infectious principle in such cases we are clearly taught the importance of a prompt removal of retained material in the uterus and the necessity for thorough cleanliness subsequently.

No woman is safe with such material enclosed in the uterine cavity, nor can we trust to the expelling forces to cast it out. If symptoms do not point the way to a course of action a rational regard for the interest of our patient should suggest the propriety of a line of action. A case in question will illustrate this point. Some months ago I was called to see a patient, of mine who had aborted during my absence from the city. The services of a most competent physician were secured by the friends of this patient. He attended the case and assumed that the entire secundines had been cast off. The patient complained frequently of violent after-pains, but

every other symptom being regarded favorable, he ceased his visits and dismissed the case on the sixth day, believing her well. I returned home on the 7th day. On the morning of the 8th day I was called to see this patient and learned her history. I found her with a temperature of 103.4-5, pulse 130, violent headache, nausea, flushed face, rapid respiration and very anxious expression. She had all the symptoms of infection. I introduced a speculum and found the cervix very slightly patulous. Passing in a curette I removed a large fragment of decomposing secundines which had occasioned the sudden outbreak of trouble. The removal of the mass and thorough cleansing of the uterus relieved the patient, but she was dangerously ill for 3 or 4 days. In this case the symptoms of infection did not appear until the evening of the 7th day.

An examination of this case and of analogous cases will clearly show that any foreign material of organic growth left within the uterus becomes the nidus for development of micro-organisms, which not only act upon the dead tissue but generate ferments which are noxious to living tissues. Auto-infection is the inevitable result, whether the organism originates within the dead tissues or is introduced from without; the results are practically the same, since they prove that infection would not take place in the absence of a pabulum favorable to their multiplication, and the ferments are impossible in the absence of the organism which produces them. The clinical test will prove this view, for it can be shown that in the largest number of cases the prompt removal of the necrotic mass is followed by an immediate

subsidence of symptoms which are dependent upon the introduction of the toxic principle into the circulation. It is quite demonstrable in the clinical test that the peculiar organism present in the necrotic mass is responsible for subsequent events in the progress of the case, for it can be shown that simple removal is not always sufficient to arrest a toxæmia thus inaugurated. If infection has reached beyond the area of necrotic tissue to the uterine walls, into the tubes or into the pelvic cavity, it may continue its destructive influence at will. In extensive injuries to the cervix, as along the genital canal, shreds and masses of living tissue may soon lose their vitality and become in like manner foci for infection.

I have seen this illustrated in more than one case of extensive cervical tear where it was necessary to remove with the scissors or curette sloughing particles which were furnishing a pabulum for micro-organisms to feed upon and where the clinical history of the case clearly told the story of a toxic influence. Upon removal of the necrotic tissue and repeated and thorough cleaning of the wounded tissue, repair set in and the symptoms of toxæmia disappeared.

I am clearly of the opinion that an early recognition of clinical phenomena in the lying-in woman and a prompt and thorough examination of the entire genital tract will enable one to recognize the causation of symptoms, which when followed by judicious local treatment will at once disappear. Delay at this time is exceedingly hazardous for within a few hours a fire kindled in the vaginal canal or cervix uteri will spread with great rapidity to the uterine cavity, tubes,



or even to the pelvic peritoneum. The route may be either by continuity of tissue or by the lymphatics.

In one case observed with a medical friend the infection clearly originated in the cervix, which was torn into numerous fringes, some of which were necrotic. In a few hours the pelvis was literally filled with inflammatory lymph, the patient's temperature was about  $105^{\circ}$  and she was critically ill. By the use of local treatment to the cervix, thorough cleansing of the uterine cavity and rapid purgation with salines, the effused material disappeared by absorption. She had the physical signs of a perfect pelvic cellulitis. Pus formation was hourly expected but fortunately its advent was prevented by the prompt methods instituted. No one can foretell the development which will ensue in any given case. The moment infection begins the fire bursts forth by such routes as are most favorable. It seems to attack those tissues which are most inviting, and once under way its general spread is only limited by the resistance of the tissues which are attacked. Should the uterus be flabby and relaxed with contractility and retractility both in abeyance, a metritis is an almost sure result. If the endometrium is in favorable condition local extension along the uterine cavity is the route chosen until the tubes are reached. Once within the tubes the mechanical conditions of the tube will determine the character of the development. The process may be confined to the tubes, giving all the physical characteristics of the pus tube, with subsequent drainage into the uterus or pelvic cavity, or by some other route; pelvic or general peritonitis may be associated with these conditions or it

may occur as an independent phenomenon, running its course, as it were, independent of uterine or tubal involvement, but dependent, in my judgment, upon their primary influence.

What part the lymphatics play in the development of these several forms of intra-pelvic inflammation it is difficult to assign in any given case. From my own personal observation of cases seen in their acutestages and in cases subsequently operated upon long after the subsidence of acute symptoms, I am inclined to believe that the process extends by contiguity of tissue and along definite routes, though it is quite apparent that mechanical conditions do materially influence the progress and direction of the inflammatory action.

We owe to abdominal surgery the major part of our knowledge of the pathology of the intra-pelvic region in woman in so far as the pathology of this region has been influenced by infection occurring during the puerperium. The origin and spread of a septic process may be traced throughout its entire course by the character of the lesions found in the pelvis by opening the abdomen either at the time of the acute stage or at a subsequent period when the lesions left after the subsidence of acute symptoms are of such a character as to necessitate their removal. These lesions indicate the intensity of the process and show a complete or almost complete destruction of tubes, ovaries and adjacent tissues by the conflagration which has passed over them. One has only to study these cases and their damaged organs to realize the importance of a prompt recognition and treatment of an infection during the puerperium. That so many

infected women escape death and pass through the lying-in period with no graver lesions than are subsequently found in a large percentage of these cases is difficult to explain upon any other theory than the one which recognizes differences of character in the organism present or inherent resistance of tissues in the individual case. Other influences, of course, are at work to limit the violence of the septic process, such as the favorable surroundings of the patient and the treatment instituted by the obstetrician, but these influences are indefinite, since they only prevail in the exceptional case.

Treatment, when instituted, must be prompt and radical and must deal with the local process in a mechanical way. The therapeutic agents at our command for internal administration are exceedingly limited and are addressed to the relief of symptoms rather than to a removal of the infectious principle.

Of the so-called germicides we have none which can be employed internally to destroy a micro-organism or the toxic principle manufactured by the organism.

We must, therefore, rely almost entirely upon local agencies and upon surgical methods to arrest a process which extends by its mechanical influence along a route of its own selection.

Whilst we are dealing, then, with an organism which multiplies with marvelous rapidity under influences favorable to its growth and whilst we possess no agent which can arrest its multiplication after it has invaded fluids and tissues beyond the reach of mechanical measures, it can not be assumed that we have reached the limit of therapeutic measures in all cases. Where the indications for surgical interference are not pronounced

we may yet do much to subdue symptoms and to maintain the powers of resistance. By the free use of calomel or the salines the intestinal tract may be used to eliminate the products of inflammation by promoting absorption of effused material within the pelvis. Free and repeated catharsis undoubtedly renders a valuable assistance if employed in the early stages of peritonitis or of intrapelvic effusion. It may prove harmful and depressing when employed after pus has formed or the heart's action has been greatly weakened.

In the beginning of a septic process the vagina and uterus should be thoroughly washed and cleansed with an antiseptic solution. The method should be addressed to the uterine cavity and should be so thorough as to remove every trace of blood-clot, retained placenta or necrotic tissue. A firm retraction of the uterus will usually follow this procedure. All wounds of the genital tract should be kept in a thoroughly aseptic condition. It is surprising how speedily a septic process can be arrested by this plan of action if the process has not extended beyond the endometrium.

If the parenchyma of the uterus or the tubes and peritoneum have become involved, this method of treatment will not be sufficient.

The use of hot water vaginal douches, of salines to induce purgation, of opium to quiet pain, of antipyretics to lower temperature, of nutritious diet and stimulants to sustain strength and circulation, are variously indicated, according to the condition of the patient. If pus forms, the indications for drainage are apparent and nothing short of an abdominal section should be considered if the pus sac cannot be reached by vaginal

drainage. The surroundings and condition of the patient must necessarily influence the decision of the operator in the selection of the method of drainage. Mr. Tait and the followers of his school advocate the abdominal section as offering the best results for the patient. Mr. Tait not only removes the tubal pus sac, but boldly amputates the uterus when this organ is the seat of infection and of abscess formations. Such radical measures necessarily involve a high rate of mortality, but they offer the only hope of cure in such extreme cases.

It is quite evident that a septic process should be early recognized. There are pronounced symptoms to direct attention to the onset of infection if they are properly interpreted. The invasion is usually announced with chilly sensations, or a decided chill; a rise of temperature may or may not follow; this symptom is not altogether reliable. A sub-normal temperature I have observed in several cases. The lochial discharge usually ceases, the mammary glands are flabby, the milk flow either not making its appearance or disappearing a day or two after it has been established. After-pains are usually more pronounced. The uterus is large, relaxed and flabby. Tenderness over the abdomen, with distension, is observed in a number of cases. The pulse is quick and feeble, jumping to 120 to 130 beats per minute. The facial expression becomes pinched and anxious, whilst the mental faculties are usually alert and restive; the skin is clammy and relaxed. These symptoms begin gradually from the first to the sixth day after labor and rapidly increase from day to day if methods of treatment are not promptly instituted to arrest the in-

fection. A few hours will indicate the rapid onset of an infection, the patient becoming alarmingly ill between the visits of the physician.

It may be laid down as a rule that when a lying-in woman is not doing well after labor, there is a grave reason for her disturbance. The shock and ordeal of labor are not sufficient to account for disturbances of pulse, temperature and respiration or for sensations of chilliness, of discomfort or depression. The presence of such symptoms should create suspicion and suggest careful observation. A physical exploration should be made with promptness, to determine the condition of the vagina, uterus and intra-abdominal organs. The obstetrician cannot safely fold his hands and rely upon the reparative processes. Whilst it is true nature may be competent to deal with these minor forms of disturbance, the patient is exposed to the risk of subinvolution and of minor intra-pelvic lesions which may permanently impair her health.

How many cases of permanent uterine and tubal disease originate in the lying-in chamber it would be difficult to enumerate. It is sufficient to know that abortion and child-bearing impose serious burdens upon the reproductive organs and that the management of these functions upon strict aseptic surgical principles will eliminate many sources of permanent damage to these organs.

We owe to a careful and strict prophylactic management of the parturient woman the most striking results achieved in hygienic science. The rules which apply to prophylaxis before labor apply with equal force to management and observance of the lying-in woman during the entire period of her lying-in.



The period of infection is extremely variable. It may antedate labor by hours, days or weeks. There can be little doubt of the fact that an old salpingitis may be rekindled during parturition and become the starting-point of infection. Infection may start during the expulsive stages of labor through the septic conditions which accompany the management of the parturient act. It may occur at any hour subsequent to the birth of the child through similar septic surroundings. Or it may not occur until some days subsequent to delivery.

In a patient I saw in consultation some two years ago with a medical friend, the patient was up and around and had been dismissed by her medical attendant. On the 21st day after labor she was seized with symptoms of infection, from which she died one week later in spite of every method of treatment. In this case there was not the slightest trace of a local lesion and she perished from a pure septicæmia, the origin of which could not be traced or explained. With such facts before us the period of safety from infection is one of wide limitation and shows the absolute importance of a strict regard for hygienic methods during the entire period of involution.

I am convinced from my personal observations of these cases, that grave intra-uterine and intra-pelvic diseases are established during the post-puerperal stage by too early relaxation of attention and observation of our cases and by a too strict reliance upon the reparative function. This rule I cannot apply to all cases, especially where a normal labor has supervened, but it has a practical application to a large class of cases presenting evidences of a faulty lying-in or where a difficult or artificial labor has occurred.

From a clinical study of the pathological conditions following abortion and labor we may regard infection as the chief causative influence at work in provoking the symptoms and conditions witnessed. Traumatism, however severe, is not wholly sufficient to account for the inflammatory troubles observed unless the uterus is extensively ruptured, the peritoneum torn or intra-pelvic hæmorrhage results. An aseptic wound of the genital tract will undergo repair with a mild grade of aseptic fever, but let the lesion however great or small become infected and a train of occurrences will ensue which may prove as destructive to the local tissues and to the life of the patient. The conditions which limit the destructive influence of a septic process are necessarily variable. The result of an infection is to a large extent problematical. The most important fact for our consideration in dealing with the parturient woman is to institute strict prophylactic measures in every case and to attack the infectious process at the very earliest moment possible. Confidence in any other method of managing the parturient woman will lead to barren regrets.

#### HIPPURIC ACID AS A DIURETIC.

This acid, obtained from the urine of the cow, is a favorite diuretic with many French practitioners. Dujardin-Beaumez prescribes it combined with lime.

Hippuric acid, 25 grammes.

Milk of lime sufficient to neutralize it.

Simple syrup 500 grammes.

Essence of lemon to flavor:

Four to six teaspoonfuls daily. As before mentioned, it is excreted in the urine as benzoic acid.—*Provincial Medical Journal*.

MARYLAND MEDICAL JOURNAL,

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BALTIMORE, OCTOBER 21, 1893.

**Editorial.**

PUERPERAL ECLAMPSIA.

This is a theme which never loses its interest for the practitioner, since at any moment he may be brought face to face with its awful necessities. He is ever ready to learn how able and thoughtful obstetricians have grappled with eclampsia of the parturient woman, especially if the issue has been favorable.

In the *N. Y. Jour. Gynecology and Obstetrics*, August, Dr. Charles M. Green, of New York, reviews the records of the Boston Lying-In Hospital touching this matter.

There were of *ante-partum* eclampsia, 13 cases; of *intra-partum*, 8 cases; of *post-partum*, 15 cases.

In *Ante-partum Eclampsia* the author believes it to be "certainly legitimate to endeavor, when it can be done without undue risk to the safety of the maternal life, to treat it without obstetric interfer-

ence," and believing that well-directed efforts will in a small proportion of cases succeed. The treatment lies first in an effort to control the convulsion by ether inhalation in preference to chloroform. Chloral hydrate per rectum is used as a sedative between the attacks Morphia is not used. The action of the skin is excited by the hot-air and hot-water bath and the careful use of pilocarpin. The bowels are affected by elaterium, croton oil and enemata, and the kidneys by a weak solution of cream of tartar, digitalis and acetate of potash. The hypodermic use of brandy, digitalis and nitro glycerine is practised, but venesection is not approved and never performed. When labor has been induced, manual dilatation is preferred to other means; in some difficult cases the cervix has been divided. "Podalic version and manual extraction is preferred to forceps, unless the head is engaged." Of the thirteen cases in this class the maternal mortality was six, or forty-six per cent.; the foetal mortality, nine, or sixty-nine per cent. Of the whole number, labor was induced in six, non-viable, and not induced in three; in the four viable cases it was induced in all.

*Intra-partum Eclampsia.* Delivery is practised as soon as possible upon the first seizure under an anæsthetic, and the patient subsequently treated with chloral, pilocarpin, hot baths, mild diuretics and stimulation, if necessary. The mortality in this class, of eight patients, shows the loss of two mothers, or twenty-five per cent., and two children, or twenty-five per cent. One of the latter, however, was killed by craniotomy, owing to a deformed pelvis in the mother.

*Post-partum Eclampsia.* The treat-



ment in these cases is the same in the main as that in intra-partum cases when the foetus has been delivered. It consists in sedatives and mild stimulation of the kidneys. Of the fifteen post-partum cases presented all but one were at full term and twelve were primiparæ. Two cases were twin pregnancies. The mortality was: one mother, or six and two-third per cent.; children, two, or twelve per cent. Of the latter, however, one died from cerebral hæmorrhage on the third day and the other was non-viable.

The *general result* shows a maternal mortality of twenty-five per cent. and a foetal mortality of fifty-two per cent. but if the non-viable children be excluded the foetal mortality is reduced to eighteen per cent.

In the discussion of the paper before the American Gynæcological Society, Dr. Davis called attention to the great value of calomel as a diuretic in these cases; and Dr. Green closed with the remark that he advises his patients toward the end of pregnancy that they should use a chamber at least once in 24 hours, and when they found the urine concentrated or strongly acid they should notify him of the fact. He believes that the continual irritation of a strong and acid urine is very prejudicial to the interests of the patient, and may lead on to other symptoms which may culminate in eclampsia.

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#### THE LIBRARY OF THE MEDICAL AND CHIRURGICAL FACULTY.

It will be observed from a communication addressed to the JOURNAL by Dr. G. Lane Taneyhill, which appears elsewhere

in the present issue, that an addition of a number of new books has been made to the Faculty library. These books have been selected with care as reference works and will be found of practical use to those who wish to consult them. At no time in the history of the Faculty has its library been so carefully managed. It contains, now, not only a large number of rare and useful works, but is receiving the more valuable foreign and home periodicals as they appear, and is from time to time adding such books and pamphlets as are demanded by the requirements of the profession. We can not speak of this library with sufficient earnestness to impress upon the profession of our city and State its importance as an educational influence. It is an exponent of what is best in the literature of the profession in Maryland and is an institution in which every physician in the State should take pride and interest. It merits the earnest support of the physicians of our State, since it is a common property which the profession can use and improve by accepting membership in the Faculty.

With the growth in membership of the different organizations and other medical institutions in the State the library should receive that consideration and support which its value to the profession will certainly justify. There is no other medical institution in our State with such historic associations and influences around it as the Faculty and its library. It comes down to us from the past with the work of the founders of professional life, influence and activity in this community stored away among its archives or garnered on its shelves. It is a record of our day as of the times which



have preceded us to which the historian of the future must turn. As the work of today becomes the history of tomorrow, is it just to ourselves or to the interests of our profession to undervalue the influence of our State medical library? Rather let us give aid and encouragement to such an influence for professional advancement in our day and generation.

#### DEATH OF THE "FATHER OF OVIARTOMY" IN ENGLAND.

Whilst the credit of the operation of ovariectomy has been conceded to Ephraim McDowell, of Kentucky, the credit of introducing and popularizing this procedure in Europe has been awarded to Mr. Charles Clay, of Manchester, England. The death of this remarkable man, at the advanced age of 92, took place at Poulton-le Fylde, England, on Sept. 19th.

Few men in the medical profession have lived so long and to so useful a purpose as Mr. Clay. The service he rendered to abdominal surgery will survive long after his noted personality has been forgotten. In every sense he was possessed of a strong and vigorous character which impressed itself upon every phase of work which engaged his attention. In September, 1842, whilst engaged in a large general practice, Mr. Clay performed his first operation of ovariectomy, removing a growth weighing 36 pounds. The patient made a prompt recovery. Following very closely upon this case he operated in fourteen more cases with a similar result.

He had seen Lizars operate in 1823, but he claimed that he was the first sur-

geon in Europe who had operated by the large incision. Up to 1857 he had operated on 395 cases with a mortality a little over 25 per cent. Sir Spencer Wells began his career in 1858, after having witnessed an operation performed by Mr. Clay. Mr. Clay at that day was ahead of all other surgeons in this field and he had placed the operation upon the footing it has since occupied.

In 1845 he performed with success the extirpation of an entire fibroid uterus and hence was in the lead of all other operators. His claim to the title of "Father of Ovariectomy" was conceded to him by Mr. Tait and others.

Apart from his great work as a surgeon, Mr. Clay was an authority in geology, archæology and numismatics, and was the author of a large number of books and pamphlets on various subjects. During his entire life he was a vigorous and incessant worker. He referred to his life's work in the following language: "Some men have got baronetcies, some wealth, some positions at court, but I have got peace of mind." These words were characteristic of a man who led an active, useful life, singularly exempt from affectation and self-esteem, and noted for its earnestness and simplicity of purpose. That he should have reached a ripe old age possessed of every faculty, interested in medical and general topics and devoted to the pleasures of his garden, is an illustration of the fact that the most earnest and serious duties do not forbid, even to the busiest of men, the pursuit of studies and avocations which are conducive to long life and rational enjoyments.

The life of such a man as Charles Clay is worthy of the most careful study.

## Reviews, Books and Pamphlets

*Reactions; A Selection of Organic Chemical Preparations Important to Pharmacy in Regard to Their Behavior to Commonly Used Reagents;* by F. A. FLUCKIGER, PH.D., M.D. Authorized English edition. Translated, Revised and Enlarged by J. B. Nagelvoort, Analytical Chemist to the Pharmacy-Chemical Laboratory of Parke, Davis & Co. Price \$2.00. G. S. Davis Publisher, Detroit, Mich., 1893.

The name of such a master as Prof. Fluckiger is sufficient guarantee that the volume embodies the result of long and thorough scientific research. This work cannot fail to be of practical value to the progressive pharmacist and chemist. The style and typographical parts are excellent.

*Saunders' Question Compend; Essentials of Bacteriology; Being a Concise and Systematic Introduction to the Study of Micro-organisms; for Use of Students and Practitioners;* by M. V. BALL, M. D. Second Edition. Philadelphia, 1892: W. B. Saunders. As an aid to the practical study of bacteriology this book is very useful, while it will give valuable information to those unable to go into practical laboratory work.

## Correspondence.

Library of the Faculty,  
St. Paul and Saratoga Sts.

BALTIMORE, Oct. 12, 1893.

*Editor of Maryland Medical Journal:*

DEAR SIR:—I regard it of sufficient interest to the members to announce

through your well-circulated Journal that the old Library Board has lately placed in the library, for the use of the members, the following valuable new books:

Fagge's Principles and Practice of Medicine; Cazeaux and Tarnier's Midwifery, with appendix by Munde; Hare's Text-Book of Practical Therapeutics; Moullin's Surgery, edited by J. B. Hamilton; Sutton, on Ovaries and Fallopian Tubes; Tukes' Dictionary of Psychological Medicine, two volumes; Vaughn on Ptomaines and Leucomaines; Whitla's Dictionary of Treatment; Vierordt's Medical Diagnosis; Abbott's Bacteriology.

This list of new and standard medical books now available to the young practitioners should induce a much larger attendance upon the library. Tukes' Dictionary, in two volumes, covers the entire range of psychiatry and allied subjects, and is especially adapted to the needs of the general practitioner.

In Cazeaux and Tarnier's work we can consult leaders in their specialty who can say "I can say" rather than "It is said," for the student of today wants to read the results of direct observation.

In Moullin's Surgery the illustrations, especially the colored plates, will excite marked attention on account of their practical bearing on useful points in surgery. The young surgeon who seeks for concise advice in *treatment* will feel that his particular wants have been understood and intelligently met.

J. Bland Sutton, in his work on The Ovaries and Fallopian Tubes, renders an immense service to the general practitioner as well as the gynecologist in the study of pelvic diseases, especially in the

field of pathology and differential diagnosis.

Whitla's Dictionary of Treatment is, certainly, the recorded experience of a "practical scientific therapist." And Vierordt's Diagnosis is useful and helpful to the student and practitioner every day in the year.

Faternally yours,

G. LANE TANEYHILL.

### CHICAGO LETTER.

*Editor Maryland Medical Journal:*

I send you a brief account of a visit to the well-known medical schools of Chicago, which may prove of interest to your readers.

Having yesterday (October 9th) passed through the excitement of "Chicago Day" at the World's Fair, with its delightful experiences never to be forgotten by the seven hundred thousand persons who participated in them, I rested this forenoon, and in the afternoon started upon a tour of inspection of the medical colleges. My doubts as to which I should visit first were quieted by the information that the Rush Medical College, the College of Physicians and Surgeons, the Womans' Medical College, the Chicago Post-Graduate School, the Presbyterian Hospital and the Cook County Hospital were all situated within a radius of two blocks. Taking the Adams and Harrison Street car, I visited first the dispensary of Rush College, which is on the same plan as other dispensaries, and overflows with patients, although a gentleman is continually on the watch to prevent well-to-do patients from obtaining free treatment.

Going next upstairs in the college

building proper, I found Prof. Senn about to operate before the class in the surgical amphitheatre, which I may very briefly describe before speaking of the operation. The amphitheatre is a large one, but of course not as handsomely fitted up as the newly-built "operating theatres," with tiled floors and water-proof walls, of the most modern schools. There were a number of physicians, doubtless invited guests, sitting within the railing in their ordinary clothes. The surgeon's and assistant's clothes and the instruments for operation were duly aseptic. Upon the wall facing the students were brass memorial tablets by the classes which have graduated from the school, gracefully arranged, each bearing the name of the class and the class motto; and above all was the class inscription, "Benjamin Rush, 1745 to 1813, Physician and Patriot." I have never seen such class memorial tablets, and was very much impressed with the beauty and the fitness of the idea.

During the lecture high-power microscopes with lamps attached were passed round the class, for the inspection of certain interesting pathological sections, which had perhaps been spoken of by Dr. Senn before my arrival.

The operation proper was the excision of an ulcerating carcinomatous tumor of the right parotid gland in a man, whose age I could not guess, as his head had been close shaven.

During administration of chloroform Dr. Senn explained in a full, clear voice that he would make the initial incision low upon the neck, so as make the way clear for subsequent ligation of the external carotid artery. A clear cut was made around the tumor, the parotid



gland was loosened as far inward as the styloid process, the point of the lower jaw was exposed, and the malar bone was removed with forceps and chisel. The tumor was thus excised, including the whole of the parotid gland and much adjacent healthy tissue. Dr. Senn then, after a few words of explanation, made a large skin flap from the side of the head, and, leaving it attached just above the ear, turned it down to cover the large cavity made by the incision of the tumor. Bleeding vessels were tied and the skin flap sutured by the attendant surgeon.

After a dissertation upon the different methods of skin planting, Dr. Senn then showed, upon a patient sent him by Dr. Hyde, Professor of skin diseases, the Thiersch method of skin grafting, upon a large surface, from which he cut away the diseased scalp.

Leaving Dr. Senn still at work, I visited the Post-Graduate School, where dispensary is kept open all day; but being told that Professor Earle was lecturing on children's diseases at the College of Physicians and Surgeons, I hastened thither. Dr. Earle, however, had, much to my disappointment, just ended his lecture. I found the professor of practice of medicine *calling the roll* of his class, preparatory to taking up the consideration of typhoid fever.

Having only a few moments to spare, I spent them in the Woman's College, inspecting the lecture halls, which are amphitheatres, new and attractive, holding perhaps 200 students. Judging from the number of hats in the ante-room, there were about 50 ladies in attendance upon the chemistry quiz in the lower amphitheatre.

Situated near the handsome parked

boulevards of the "west side," the group of buildings dedicated to medicine, to which I have referred, presents a very impressive appearance.

The Rush School and the Presbyterian Hospital (a general hospital), which stand side by side and are built in the same modern style, are very imposing. Very near them the College of Physicians and Surgeons and the Post Graduate School rise together into a stately structure. Just across the street the County Hospital is located, a great pile of buildings surrounded by green swards and flower-beds. The service of its wards, which are for both charity and pay patients, is enjoyed by all the colleges, including the adjacent school for the education of women in medicine, which, though smaller, is in freshness and cleanliness of interior most in accord with modern ideas of progressiveness. In fact, there seems no reason why dinginess and stains should not be removed from the older colleges, and even from older colleges all over the country, by a yearly application of whitewash and paint.

Very truly,  
A. K. B.

### Medical Progress.

#### THE EARLY TREATMENT OF CARCINOMA.

Dr. Howard A. Kelly, of this city, says in the *N. Y. Med. Journal*:

The large number of hopeless cancer cases constantly applying to me for relief have induced me to adopt certain stringent rules with regard to my own patients, which I have taught for the same period in my lectures at the Johns Hopkins Hospital.

The end in view is twofold—first by treating cervices liable to become cancerous, and thus prevent the formation of this neoplasm, and, secondly, to detect cancer of the cervix at a sufficiently early date to successfully eradicate the disease.

1. It is the duty of the obstetrician to see each patient at his office from two to three months after her confinement, and there to examine and make a careful record of the condition of the pelvic structures, stating accurately what lesions have been produced by the confinement.

2. Cervical lacerations should be carefully described, noting the position and depth of the tear and the appearance of the lips. Lacerations require no treatment when the lips are thin, uninfiltrated, and lie together. Thick, infiltrated, and everted lips associated with cervical catarrh call for depletory treatment followed by repair of the laceration.

3. Every woman who has passed thirty-five years of age and has borne a child should have this examination made without delay by a competent physician, and if the cervical lips do not appear perfectly sound she should be kept under observation and examined at intervals of from six to eight months.

4. Every woman over thirty-five, with a cervical tear, should be examined at least once a year for ten years, or longer, if the appearance of the lacerated area is not perfectly healthy.

5. These rules apply with special force to patients whose family history shows a marked inclination to cancerous disease.

If these rules are conscientiously observed there is not a doubt but that thousands of lives would be saved yearly

in this country alone by timely interference with a disease so markedly local and accessible in its origin.

I feel that while we are searching for a cure for cancer, the line of progress in the immediate future for the gynæcologist is clearly in the direction of prophylaxis and anticipation, either preventing or discovering the malady in its earliest stages.

#### \*JEAN MARIE CHARCOT.

In a memorial address on this distinguished physician, Dr. M. Allen Starr, of New York (*Medical News*), closes with the following tribute:

It remains to allude to his personal characteristics. Charcot was a man of great dignity, of calm repose, of even temper, of slow thought and utterance, but of much reserve power. In appearance like Napoleon, and in manner reserved and observant, he was not the type of man to be popular. Yet his dignity was one that was felt to be appropriate to a man of great power and was never assumed. With patients suffering from trifling affections he showed no sympathy, possibly no interest. With patients whose diseases were grave, or obscure, or of rare type, he was kind, attentive, interested, and was ready to spend valuable time in most careful investigation. Of this I am assured by patients who had been under his care, and who would never have come away with such kindly feeling had they not experienced his thoughtful attention. His relation to his pupils was also one of mutual interest and affection. He was never familiar with them, yet he always respected and sought their opinions, was never autocratic in the direction of their

work, and was always the subject of their devoted admiration and respect. No man could have kept about him such a number of medical workers, all loyal to him in the midst of their labors, without characteristics of many kinds of the noblest type.

His domestic life was a delightful one. He was married early in life to a lady of considerable wealth, who was enthusiastic in his work, and by whose aid many scientific undertakings otherwise impossible were carried out. He had two children, one a boy, whom it was his fond desire to see succeeding as a physician, and who gives promise of being worthy of the name. Their home—he had a large country place at Neuilly as well as a fine mansion on the Boulevard St. Germain—were superb in every appointment and contained many treasures of art, for the artistic sense was one which he delighted to indulge. He was a designer, a painter on porcelain and in oils. The tiles in his study mantel and the ceiling of one of his salons were painted by his own hand. Many of the drawings displayed at his lectures and published in his books were drawn by himself. And he delighted in gathering about him curios of every kind. He cared less for music than for painting, and always preferred the classic and Italian schools to Wagner, showing himself thoroughly French in this respect.

Like every man of eminence he had his enemies, critics in science, rivals in medicine. Yet after all their criticism is exhausted, we must admit that Charcot remains the greatest French physician since Trousseau, the greatest ornament of the medical profession of the present

age. We admire his genius; we respect him as the greatest of medical teachers; we honor him as a noble, unselfish, and truly great man.

#### THE EARLIEST MEN.

At the recent meeting of the American Association for Advancement of Science, profound interest was awakened by Dr. Daniel G. Brinton's address on "The Earliest Men." How did they come into existence? By special creation. Everything is special. The whole species is made up of special individuals; and their evolution is multiform. Scientific men are agreed that the human race did in some way arise from some inferior animal form—not necessarily monkeys. The transition may not have been gradual, but abrupt—evolution per saltum. We do not find the "missing link;" it is still missing; it may be forever missing. There are different opinions as to how many early men there were. There may have been several distinct centers, but science as well as orthodoxy points toward the conclusion that all men originated from one primal pair living in one definite place. When did these early men appear? A perplexing question. We used to be told that it was 6,000 years ago; but we now know that there were at that time thousands of men living in Europe, Asia, Africa and America. It may be that we may have misunderstood the Biblical record, or that it may have concerned a single branch of the race. It is certain, however, that man appeared late in the geological history of the globe. Human remains have been found in half a dozen places in the world under circumstances that seem to show that man lived in the Tertiary age, but the proof really seems meager. Did man appear



during the great Ice Age? The testimony from ancient caverns whose mouths had been sealed by drift, and whose contents lay hidden under stalagmitic floors, as well as that gathered from stratified gravels and other sources, proves that man probably did inhabit the globe during or even before the Ice Age. The date of that age is not exactly fixed, but was probably about 50,000 years ago, although some men of science have assigned a less and others a greater period than this.

Where did the earliest men make their home? Manifestly there were certain conditions requisite. Man requires food and generally some kind of clothing. We may reason by exclusion. The first men did not inhabit an island, for they could never have got off. They did not live where it was very cold, because they would have perished. The greater portion of the northern hemisphere was under water at the time of their advent, hence that is ruled out. They could not have lived in Australia nor in Southern Africa on account of climatic conditions and for other reasons. In short, we find them limited by conditions to the area between the Himalayan Mountains and Spain. Practically the oldest remains yet found have been discovered in the most densely inhabited regions of Europe. The sacred record treats of a particular line of human beings. The fable of the lost Atlantis and the theory of Haeckel as to the submerged Lemurien are not tenable. Eurasia was certainly man's original birthplace.

What did the early men look like? Were they altogether rude? Did they creep on all fours or walk erect? The most expert anatomists have decided,

after examining the ancient bones that have been exhumed, that there is no more difference between ourselves and those early men than there is between ourselves now. They were doubtless sturdier. They did not trouble themselves as much about dress as we do. They had reddish hair and probably a ruddy complexion, with blue or grey eyes. Their skulls were about as good as ours, except the famous one of Neanderthal, for which we have less respect than we used to have. In a word, they were men. They knew how to make a fire. Even the very oldest of all men knew that wonderful art. They also knew how to make tools from stone, wood and horn. They were conversant with a variety of instruments and tools. They had weapons with which they killed huge animals. They knew about boats. They had dwellings. They were socially inclined and lived in communities. They were brave and had wars. They endured hardships. They had good hearts and loved one another. We have positive proof that they took care of the aged and nursed the invalids among them. They had some kind of language and knew something of music. We cannot positively say that the very earliest men worshiped, but if they did so, their worship was spiritual. They had no idols. They had some sense of beauty. They decorated shells. They carved the horns of reindeer and tusks of mammoths. Those first men could travel rapidly. They encountered no very dangerous enemies. We can easily see how there came to be varieties among them, for more changes are now going on than ever before. All shades, from black to blonde, are easily explained. We may

safely conclude that the early men were essentially human and very much like ourselves, with hearts and brains, hopes and fears, woes and aspirations like our own.—*Scientific American*.

#### THE EYE SYMPTOMS OF CEREBRO-SPINAL MENINGITIS.

Dr. R. L. Randolph (*Bulletin of the Johns Hopkins Bulletin*) says:

It would seem, then, that all epidemics of cerebro-spinal meningitis have one or more eye symptoms in common, and probably those most often met with are the changes in the pupils and conjunctivitis. But every extensive epidemic is apt to be associated with a special type of eye affection. Thus Knapp, Kreitmair, Oeller, and Jacobi observed most often suppurative inflammation of the uveal tract, and make no particular mention of any other ocular complication. Wilson, Niemeyer, Ziemssen, and Hess met with keratitis, while Hirsch, in his wide experience, saw nothing more serious than conjunctivitis, which was an invariable condition. The type of eye symptoms peculiar to the epidemic which I have just described seems to have been a remarkable tortuosity and distension of the retinal veins and more or less congestion of the optic disk. The degree of venous engorgement in some of the cases was, in my experience, a unique condition, the blood appearing almost black and as though actually stagnant. The tortuosity of the veins, too, was striking. The turning-points of the veins were so abrupt that they resembled small hæmorrhages, and, as such I regarded them in one case till I was enabled later to make a more thorough examination, when I found that what I

took to be hæmorrhages were very abrupt turns in the veins where the circulation must have been almost at a standstill. These conditions are quite analogous to what was discovered in the brain in every case where a post-mortem was made. I was not present at any of the autopsies, but Dr. Potter told me that the tortuosity and distension of the veins on the surface of the brain reminded him forcibly of my description of the retinal veins, and the changes in these vessels I think can readily be understood from the condition of the brain revealed at the autopsy.

It is clear, then, that in all epidemics of cerebro-spinal meningitis a systematic examination of the eyes should be made with the ophthalmoscope, and that frequently when other eye symptoms are absent and the general symptoms are misleading, changes in the fundus of the eye will be discovered which will throw light upon the case. And again, the existence of good vision does not mean a sound optic nerve or retina, for not unfrequently do we meet, in every-day work, with a choked disk where the visual disturbances are insignificant. Of the thirty-six cases which I examined, not counting those which were affected with diplopia, only three complained of their inability to see distinctly. I regard the existence of eye symptoms, especially those where the fundus is involved, as indicating a particularly grave case. Wherever I found the condition which I have described very pronounced, I felt justified in speaking positively as regards the prognosis. I think that this type of eye symptoms is of more value as indicating the condition of the brain than the symptoms described by other writers,

such as panophthalmitis, suppurative choroiditis and keratitis, affections which, in my opinion, would be likely to have their origin in a general infection and not likely to be the direct result of the purely cerebral changes.

#### THE SURGERY OF DISEASED APPENDAGES.

M. Pozzi may be congratulated on his paper read at the Newcastle meeting. Diseased tubes and ovaries are the source of wide and indefinite pain and discomfort. Though they rarely cause death, they are very intractable to purely therapeutic treatment, and likely to recur. Prolonged rest may cure them, but they are specially frequent amongst women who cannot afford to rest. Complete extirpation has been largely practised. The vaginal hysterectomy, on M. Segond's principles, is never likely to find favor in this country, where even simple oöphorectomy is often looked upon as a mutilation. Removal of old inflamed tubes and ovaries is not always successful, chiefly because the pedicle is usually made up of diseased tissue, so that fresh morbid changes may occur. Nevertheless, in the hands of even the fairly experienced, cautious and thorough extirpation of the appendages, after due trial of therapeutic measures, has restored a large number of invalids to health and strength. When once the abdomen is opened the disease often proves to be largely external to the tube and ovary; in short, they are encumbered with adhesions. The simple breaking down of inflammatory bands may restore the parts to their functions. This good result has followed both accidental and intentional detachments of adhesions, and accounts for the success of many pure "explorations."

Certainly an exploratory operation may prove that nothing more is justifiable. But when the ovary is found distinctly diseased few operators care to leave it behind. We refer to inflammatory disease, and put aside questions about the tubes. M. Pozzi saves the ovary by the excision of the diseased part, the cautery being also used under indications which he specifies. He compares the operation to resection of bones, and claims good results. The series of resections, however, remains as yet very small and very recent. More statistics are needed, and, above all, longer after-histories. The proceeding, though essentially surgical, is in a certain sense therapeutic, and all the fallacies pertinent to therapeutic questions must be considered. The stimulus of incision and cauterization may set up changes which cure disease possibly beyond the area of the ovary altogether. For the precise pathology and clinical history of the small cystic degeneration of inflamed ovaries is obscure and the cysts surrounded by dense tissue may not be the real source of subjective trouble. M. Pozzi's proceeding is certainly justifiable, and we wait with interest for further experience.—*Brit. Med. Jour.*

#### HYGIENE AMONG THE ANCIENTS.

The ancients fought against evil smells as vigorously as the moderns. A process of disinfection was adopted by Ulysses, and described by Homer. Hercules too, was a practical sanitarian, but of all the ancient sanitary reformers, Moses was the most thorough and practical. He gave us the principle of the modern earth closet, although the animals of the field may be said to have anticipated him in that device. During



the best times of Greece and Rome, public sanitation was much studied, and the supervision of hygienic arrangements was an office of dignity among the Greeks and Romans. The cleansing and disinfection of streets and sewers were placed under a high officer of state because, as Justinian tells us, "uncleansed and unrepaired sewers threaten a pestilential atmosphere, and are dangerous."

Sanitary science owes something to the fathers of medicine also. Hippocrates was the first sanitarian who wrote an entire book on public health, and his discourses upon pure air, pure water and pure soil are instructive reading at the present day.

It is exceedingly interesting and suggestive to find these ancient writers elucidating principles which the exact investigations of our time have demonstrated to be the true foundation of sanitary science.

In Mexico it has been shown that sanitary science must have reached a high degree of perfection in its history. Previous to the conquest of the country by the Spaniards, the towns were thoroughly and efficiently supplied with water by the most perfect system, but the teachings of those early times were not permanently effective. The magnificent civil works were doomed to suffer ruin, and the world passed through dark ages of mental and physical barbarism.

The devastating epidemics of the middle ages which cut off one-quarter of the population of Europe are well known. Filth, instead of being abhorred, was almost sanctified. The monks imitated the filthy habits of the hermits and saints of early Christian times, and the early fathers commended them. Even

St. Jerome used to praise the filthy habits of hermits, and especially commended an Egyptian hermit who combed his hair on Easter Sunday only, and never washed his clothes at all. Monks up to the time of the reformation thought, or professed to think, that by antithesis, pollution of the body indicated cleanliness of the soul. Practically, indeed, it might be said to have helped to it, because the odor of sanctity which infected these monks and hermits helped them to keep apart from the temptations of the world; for the world scarcely cared to come into too close contact with these odoriferous saints.—Dr. S. A. Sanger, in address before International Congress of Public Hygiene.

#### HIGHER MEDICAL EDUCATION.

The *Medical News*, in discussing this subject, offers the following suggestions:

Where consolidation is impracticable—where for instance a great school not connected with a university has glorious memories and traditions, as, for example, the Jefferson Medical College of Philadelphia—coöperation is not impossible, on some such plan as was suggested by Provost Pepper at a dinner of the Jefferson alumni. Let medical students who come to Philadelphia, said Dr. Pepper in effect, attend lectures where they will—at the University, the Jefferson, Medico-Chirurgical College, or the Woman's Medical College. Let all the laboratory and hospital facilities be open to them. Let them be students of the medical faculties of Philadelphia, and let them, by having choice of teachers, stimulate the teachers to generous rivalry. Something like this seems to be the thought, too, of Dr. Da Costa, when he says: "The future of medicine lies in the universities and

in such great schools as can vie with them in clinical and other facilities."

If the undergraduate and post-graduate schools of cities like Philadelphia choose to overlook mere personal interests, they have it in their power to give, by their coöperation, the greatest impulse of the century to Higher Medical Education in America.

#### THE ENERGY OF LIVING BEINGS.

Professor R. J. Anderson concluded his course of biology at Queen's College, Galway, by delivering a lecture on the Energy of Living Beings. After illustrating the fact that a living organism is the centre of force by reference to many phenomena of animals and vegetables, he pointed out that the substance of a living being has the property of constantly receiving, storing, and transmitting energy, and that a living organism manifests properties akin to the silent forces of nature. An organism might fail to admit forces or accumulate energy that is beneficial to it, and so an undue expenditure of force resulted, leading to the total extinction of the organism. The undue receptivity might be disadvantageous if, in place of being stored up, it became quickly reproduced again, so that the forces were simply reflected. The higher organisms were remarkable in their powers of resisting for a time the simple reflection of energy, and in their power of storage and reproduction. The highest of all was the production of new material forces, and evolution of not merely new forms, but of coherent and permanent forms.—*Brit. Med. Journal*.

Polk's Medical Register of the United States contains 105,000 names.

#### Recommendations of Therapeutic Agents.

Sennine in Gynæcology.—The greatest difficulty heretofore experienced in the treatment of cervicitis, abrasions, fissure and ulcerations of the os uteri have been from the constant interference of the acrid discharges that effectually prevented any healing process. The various washes and solutions, owing to these poisonous discharges, have been only of temporary service. Sennine applied freely in its powder form coagulates the oozing serum and thus hermetically seals the part until nature restores its integrity. The application may be preceded by a thorough syringing with one part of Sennine to fifty of water. This solution is also very efficient in leucorrhœa. If at the same time dessertspoonful doses of dioiburnia be given internally three times daily the cure is very rapid and permanent.

#### Medical Items.

St. Luke's Hospital in Detroit has been left \$200,000 for the care of the aged poor.

Nitrate of silver stains are easily removed by painting the part with tincture of iodine and then washing in dilute aqua ammonia.

The number of medical schools requiring attendance on three or more courses of lectures was, in 1882, twenty-two. In 1891 the number was eighty-five.

It is said that about half a million cases were treated in the fifty-odd dis-

dispensaries of New York City last year. The patients at German dispensaries are Germans only; those at New York Dispensary in Centre Street, Italian; at East Side Dispensary, Hungarians and Bohemians; at Bellevue, the Irish; at Mount Sinai and Good Samaritan, Jews. Rivals say that patients come to the Vanderbilt clinic in their carriages.

Dr. J. E. Reeves, of Chattanooga, Tenn., has been sued for damages by the Amick people. The doctor wrote a postal card to Dr. Mettznar, of Cincinnati, on which he stated that the many wonderful "cures" alleged to have been made by the Amick treatment in and near Chattanooga were entirely fictitious. Dr. Reeves stated that there was no evidence to show that any cases had been benefited. For all of which the Amick tribe now want damages to the extent of \$20,000.

An ambulance car is to be introduced upon the electric street-car system of St. Louis, Mo. It is practically an emergency hospital upon street-car wheels. The springs are so made as to prevent all preventable jars to the occupants of the car. Three large public hospitals are located along the line of these roads, and the city dispensary is in the heart of the city along the same roads, so that patients can be conveniently conveyed from the dispensary to the hospitals, as well as from all other portions of the city. Horse ambulances still will be needed to supplement the work of the car ambulance.

Our medical colleges are now being filled with ambitious young men. Many

of them have doubtless received words of advice from parents, instructors and friends. All, however, may well bear in mind the words of Sir Astley Cooper, spoken many years ago at the Royal College of Surgeons: "Gentlemen, you are about to enter on a noble and difficult profession; your success in it depends in three things; First, on a good and thorough knowledge of your profession; second, on an industrious discharge of its duties; and third, on the preservation of your moral character. Without the first—knowledge—no one can wish you to succeed; without the second—industry—you cannot succeed; and without the third, even if you do succeed, success can bring you no happiness.—*Med. Rec.*

The newly created School of Pharmacy of the University of Texas was opened on Oct. 2nd with a faculty consisting of Dr. James Kennedy, professor of pharmacy and lecturer on botany; Dr. S. M. Morris, professor of chemistry; and Dr. E. Randall, professor of materia medica.

The medical work of the Marine Hospital Service for the last fiscal year shows that 53,610 patients were treated during the year. Of the 906 surfmen and keepers of the Life-Saving Service examined, 64 were rejected for physical causes; and of 1,344 pilots examined, 60 were rejected on account of color-blindness. But one officer was detailed for cruising duty with the Revenue-Marine Service. The surgeon-general recommends that pilots should be re-examined regarding their color-sense every three years, and that a general visual test and a test for hearing should be applied at the same time as the color-test.







